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Guest Editorial

Epistemic injustice and the mental health service user

John Rawles (2004, p. 230) famously asserted that 'Justice is the first virtue of social institutions, as truth is of systems of thought'. Truth and justice, he argued, are not to be compromised, and laws and institutions must be abolished or reformed if found to be unjust. Nevertheless, justice tends not to be the first principle of appeal or consideration in ethical deliberations in mental health care. For example, breaching people's autonomy through involuntary or coercive treatment, or containment through the use of practices, such as seclusion (reviewed by Happell in this edition), are common but profoundly ethical problems within mental health services. Such practices are typically justified with reference to the principle of beneficence, that they are in the person's best interests, and/or non-intervention would lead to harm to the individual or others. Justice does not typically enter the equation, except in the sense of 'procedural justice', that is, ensuring that people are seen to be dealt with fairly by having access to second opinions, timely reviews, and otherwise competent treatment. There are, however, other important conceptions of justice that are at least as relevant to mental health service provision.

Some mental health services or systems which have treated people poorly in the past have embarked on a process of reconciliation with former service users, which might be described as a process of 'restorative justice'. Often one hears that mental health services have not received a fair allocation of resources relative to other areas of health expenditure (an appeal to distributive justice). Occasionally too, people make impassioned pleas to address 'social injustice' and mental health, or the stigma, discrimination, marginalization, and violation of human rights associated with being labelled as having a mental illness or different. For example, Johnstone (2001, p. 208) in one of the rare occasions in which any conception of justice has been explicitly addressed in this Journal, argued that 'it is a moral imperative of the first order' to listen to those construed as socially deviant because of mental health problems and to overturn the stigma of difference. Most readers would acknowledge that many people who come to use mental health services also experience and are deeply affected by 'social injustice' as a consequence of a range factors, such as poverty, class, ethnicity, and gender. However, there is a tacit acceptance of social injustice as inevitable, and addressing structural inequalities (poverty, systemic racism etc.) is more often than not considered beyond the purview of mental health services or nursing practice to address.

More recently, Fricker (2007) described two forms of epistemic injustice which cause harm by diminishing people's capacity as knowers and ultimately undermining their status as citizens. 'Testimonial injustice' occurs when prejudice causes a hearer to ascribe a deflated level of credibility to a speaker's words or testimony. Actual and potential testimonial injustice is endemic within mental health service delivery. For example, central to mental health legislation is the idea that some people lack the capacity to make decisions and it follows that what they might say, how they construe problems, their choices and preferences lack coherence, logic, or credibility. It is not surprising then that the testimony of all or most people who use mental health services might be considered suspect.

For example, I recall feeling profoundly affected by a small dose of a commonly prescribed psychotropic drug. When I reported this to the prescriber, my claims were met with incredulity, as the reaction I experienced was quite unusual. As a professional, the veracity of my reporting of the symptoms or behaviour of others had never been called into question in the manner that it was when I was in the position of patient. Since the advent of behaviourism and subsequent development of neuro-imaging technologies, the self-reports (or introspections) of patients more often require corroboration or more 'objective' verification. Often when observations or self-reports are translated onto a scale, the number is ascribed greater significance than a person's testimony, and epistemic injustice is subtly perpetuated.

Instances of testimonial injustice might not seem to have the gravity of other ethical problems, such as coercion. However, the significance of testimonial injustice is that it is foundational to other forms of injustice.

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Procedural and social justice often depends on testimonial justice being done. It is widely recognized that it is unjust to imprison, forcibly restrain, and drug people without good cause, and in psychiatry, this rests on the credibility of the person's testimony and notions of informed refusal, as well as consent. Many service users and carers continue to report perceptions of being unjustly treated and harbour a sense of grievance about not being listened to or having their knowledge disrespected, despite scrupulous attendance to procedures.

Fricker (2007) coined the term 'hermeneutical injustice' to describe a social situation in which a person is impeded from making good sense of an experience because of a collective hermeneutical block or prejudice. An overconfident assertion of a psychiatric diagnosis or overzealous belief in biomedical explanations may also lead to hermeneutical injustice. For example, a person may accept the often uncritically espoused 'biochemical imbalance' explanation for their low mood and forgo the opportunity to explore what historical, social, or environmental factors may actually have contributed to their 'depression'. This premature foreclosure of aetiological exploration was obvious in the audit of clinical files I undertook in an adult mental health service (Lakeman 2008). It was apparent from a detached reading of files that relationship problems with a spouse were antecedent to some repeat admissions to hospital. Nevertheless, the patient was viewed as the depressed person in need of treatment, a view seemingly shared by the spouse, health professional, and the patient (whose ambivalence with the relationship was rationalized as a symptom). The opportunity to explore the problem as a relationship/interpersonal problem rather than a biochemical one was missed. Like other forms of testimonial injustice, hermeneutical injustice can seed a chain of injustice; for example, the needless and ineffectual consumption of scarce help resources and engulfment in a chronic, dependent patient role.

Much has been written about the limitations of diagnoses in psychiatry, but perhaps the greatest of problems arise when their use presumes unfounded aetiological and prognostic certainty; when they don't illuminate the problem or provide for an effective solution. Various schools of psychotherapy, and more recently nursing (Crowe *et al.* 2008), have put increasing emphasis on formulating explanations for how problems develop, are maintained, and can be resolved. The measure of success is the degree to which the formulation fits with a person's values and beliefs and leads to positive resolution of problems.

Effectively formulating problems requires openness and humility. Listening to people is necessary, but it is insufficient to effectively help people if filtered through hermeneutic mufflers which transform every utterance into symptoms or constructs of a predetermined pet theory. I might add that service users do not generally come to seek help with a clear, explanatory framework, and they are prone to some of the same hermeneutic blocks as health professionals. Helping people to formulate and work out problems (drawing as necessary on psychological theories, but not imposing them) provides a reason for listening and gives value to people's testimony. This orientation is one of embodied justice.

Forms of epistemic injustice can be perpetuated in subtle ways, but with far-reaching consequences. Obviously, health professionals need to be scrupulous in their determinations of decisional capacity and acknowledge its dynamic nature. Thus, it is a matter of justice that health professionals do not over extend judgments of in-capacity, and acknowledge that people might still be competent in expressing preferences which ought to be honoured. Encouraging the preparation of advance directives, and honouring them on occasions where capacity may be diminished, is a positive way of promoting epistemic justice.

Mental health service provision throws up some particular problems in relation to developing and sustaining just services. Like the problems which people bring with them to mental health care, justice is multifaceted and multidimensional. While often it may seem that addressing injustice is too big a problem for any but the most heroic of individuals, much injustice is underpinned by testimonial injustice of various kinds, which we as health professionals are implicated in perpetuating. Mental health professionals need to reflect on the way we engage with service users, consider their testimony, and construct problems. To do so will have far-reaching implications for creating just institutions, and ultimately, just societies.

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