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Epistemic injustice during the diagnostic process in psychiatry

a change in narrative

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Abstract

Mental health care has been widely criticized for failing to implement shared-decision making. While shared-decision making has been advocated for regarding therapy, it still needs to be addressed, mainly regarding the diagnostic process. This thesis critically examines the diagnostic process by subdividing this process into three separate components: i) patient testimony, ii) observation and conclusion of the diagnostician, and iii) diagnostic criteria. This subdivision aids in accurately identifying epistemic injustice in these components when a more general approach may fall short. The simultaneous yet specific targeting of epistemic injustice in these components is needed to solve epistemic injustice in practice. I argue that epistemic injustice arises on an individual level due to implicit biases by diagnosticians toward the patient and on a structural level due to the structural marginalization of patients in society. The individual relationship between patient and diagnostician is analyzed, establishing the imbalance in power dynamics in this relationship as a significant contributor to the harmful effects of epistemic injustice during the diagnostic process. I argue for increased power of decision to patients to solve epistemic injustice on a structural level. It is concluded that increasing patient knowledge in the diagnostic criteria by adopting first-person perspectives may prove fruitful in formulating more accurate and morally just diagnostic criteria.

Keywords: mental health care, mental health, psychiatry, diagnostic process, epistemic injustice, patient knowledge, first-person accounts, shared-decision making, patient participation

Abbreviations

APA	American Psychiatric Association
DSM-V	Diagnostic and Statistical Manual, fifth edition
SDM	Shared-decision making

Table of contents

Introduction	page 4
Chapter 1: Epistemic injustice as a theoretical framework	page 8
1.1 <i>The diagnostic process</i>	page 8
1.2 <i>Epistemic injustice</i>	page 9
1.3 <i>Epistemic injustice as proposed by Fricker</i>	page 10
1.4 <i>The effects of epistemic injustice in psychiatry</i>	page 11
Chapter 2: Patient Testimony	page 14
2.1 <i>Testimonial injustice during patient testimony</i>	page 14
2.2 <i>Testimonial smothering</i>	page 17
2.3 <i>Hermeneutical injustice during patient testimony</i>	page 18
2.4 <i>An ethically justified alternative</i>	page 21
2.4.1 <i>Testimonial justice</i>	page 21
2.5 <i>Recap chapter 2</i>	page 24
Chapter 3: The diagnostician's observation and conclusion of patient testimony	page 25
3.1 <i>Expert knowledge and training</i>	page 25
3.2 <i>Implicit beliefs of the diagnostician leading to testimonial injustice</i>	page 26
3.2.1 <i>Testimonial injustice</i>	page 27
3.3 <i>Hermeneutical injustice during observation and conclusion of the diagnostician</i>	page 28
3.4 <i>Epistemic justice as a corrective means</i>	page 28
3.4.1 <i>Testimonial justice</i>	page 29
3.4.2 <i>Hermeneutical justice</i>	page 29
3.5 <i>Imbalances in power between patient and diagnostician</i>	page 31
3.6 <i>Increased patient participation as corrective means</i>	page 32
3.7 <i>Objections to patient participation during the diagnostic process</i>	page 34
3.7.1 <i>Increased responsibility</i>	page 34
3.7.2 <i>Impaired judgment</i>	page 35

3.7.3 <i>Decision-making capacity</i>	page 36
Chapter 4: The diagnostic criteria	page 37
4.1 <i>The diagnostic tool</i>	page 37
4.2 <i>Epistemic injustices in the diagnostic criteria</i>	page 38
4.3 <i>The value of patient knowledge</i>	page 38
4.4 <i>Forms of patient knowledge</i>	page 40
4.5 <i>Solutions to combating epistemic injustice in the diagnostic criteria</i>	page 42
4.6 <i>Limitations of including patient knowledge as a corrective means</i>	page 43
4.7 <i>Objections to the inclusion of first-person criteria in the diagnostic tool</i>	page 45
4.8 <i>Recap</i>	page 46
Conclusion	page 47
References	page 49

Introduction

During a psychiatric evaluation, patients'¹ behaviors and symptoms are observed and heard by a diagnostician, who then classifies these symptoms into a diagnosis, often with the help of a diagnostic tool called the DSM-V. Despite the criticism the DSM-V has received, it continues to be a helpful tool to diagnosticians in determining mental disorders in patients and ultimately reaching a diagnosis (Krueger et al., 2014). A diagnosis is needed to initiate a form of therapy. It is required by health insurance to cover the medical bills for therapy, making the need for a concrete diagnosis apparent. The diagnostic process in psychiatry is tedious and complex, consisting of various sessions and components wherein the diagnostician aims to reach a diagnosis. However nuanced the diagnostic process may be in theory, problems in practice persist. Despite the diagnostician's careful self-reflection and attempted preventative measures against their own implicit biases, the diagnostician's observation of a patient's behavior and symptoms will undoubtedly, although unwillingly, include some form of the diagnostician's prejudice towards the social group that the patient belongs to (Merino, 2018).

The central claim I will argue for is that the diagnostic process, as described above, leads to epistemic injustice on multiple accounts due to imbalances in power and knowledge between patients and diagnosticians. I will argue that this takes place because both tools used during this process: the diagnostician's training and mind and diagnostic criteria formulated in a widely criticized diagnostic tool, may be suboptimal ways of reaching a diagnosis. My arguments are supported by the theoretical framework of epistemic injustice first introduced by Miranda Fricker and later built on by Carel and Kidd and Kristie Dotson.

¹I am conscious of the fact that in psychiatry the term "patient" is disputed due to – among other reasons - disempowering narratives and negative connotations. Alternative terms are among others e.g. care user, client, user .(Costa et al., 2019) The use of these alternative terms may be advised in situations wherein direct contact with patients takes place. Empirical data shows that mental health users prefer the term "patient", or "client" (Dickens & Picchioni, 2012) For clarity purposes, I will adhere to the term "patient" as it is in line with the general field of research. Additionally, it is my opinion that refraining from using "patient" as a term may, although inadvertently, conceal the severity of mental disorders.

How this thesis is structured goes as follows. I will start by dividing the diagnostic process into three different components indisputably needed to form a diagnosis. The three components are the following:

- 1) The testimony that the patient is giving, both verbally and non-verbally
- 2) The diagnostician's observation of the patient and conclusion of the testimony that the patient is giving
- 3) Diagnostic criteria that help reduce the patient's symptoms and categorize them into a diagnosis

Hereafter, I will critically examine each component and identify the presence of epistemic injustice. A separate analysis of these components is needed to accurately identify epistemic injustice during the diagnostic process and will provide helpful solutions in practice. If these components are not analyzed separately, the risk of overlooking epistemic injustice remains. As I argue later, when epistemic injustices are overlooked in one component of the diagnostic process, alternative solutions may fail at truly solving epistemic injustice, rendering them fruitless in practice, thus implying the underlying need for a more thorough analysis.

The first chapter will be introductory, briefly exploring the diagnostic process and introducing epistemic injustice as a concept of Miranda Fricker's theoretical framework to help identify injustices. I will argue its relevance to psychiatry by discussing the implications of epistemic injustice in psychiatry and arguing how short- and long-term consequences follow. Each chapter after that will consecutively discuss a separate component of the diagnostic process, thereby identifying epistemic injustice in each component, providing an ethically justified alternative, and defending that alternative against objections.

The second chapter will address patient testimony, analyzing how epistemic injustice occurs. I will use an additional notion of epistemic injustice proposed by Kristie Dotson. I believe her conceptualization of the notion is more valuable than Fricker's, as it focuses specifically on self-silencing behavior by patients due to being structurally marginalized in prior situations (Dotson, 2011). I will propose a more empowering approach to increase patient participation to solve epistemic injustices during this component.

The third chapter will cover the second component; the observation and conclusion of the diagnostician. I will herein identify various forms of epistemic injustice and argue that this is a direct consequence of implicit biases the diagnostician holds towards the social group to which the patient belongs. I will show how difficulties are encountered when tackling epistemic injustice at the cause and propose an alternative that practically focuses on shared-decision making for solving epistemic injustice.

The fourth chapter will discuss the third and final component of the diagnostic process, namely, the diagnostic criteria. This chapter will explore the presence of epistemic injustices that arise from the formulation of the diagnostic criteria and the lack of patient knowledge that is included in them. I thereby use Bueter's identification of pre-emptive testimonial injustice to argue for adopting first-person perspectives in the diagnostic criteria (2019). I argue that diagnosticians should use diagnostic criteria that respectfully and accurately represent the diagnosis itself. Afterward, I will say how this approach may be too targeted and therefore fall short of effectively targeting epistemic injustices in the diagnostic process. I will discuss that proposing an alternative that achieves epistemic justice is challenging because it requires addressing how society conceptualizes pathological behavior and mental disorders. Lastly, after all the arguments have been considered, I will provide some concluding remarks.

A critical remark in this thesis regards the interrelatedness of the first and second components. This specific relationship between patient testimony and the observation and conclusion of the diagnostician facilitates the diagnostic process, and without it, the diagnostic process cannot occur. I will be identifying epistemic injustices separately. However, these components are interrelated and influence each other continuously. If, for example, an epistemic injustice were to occur during patient testimony, and a patient would render themselves unintelligible, then this would directly influence the observation and conclusion of the diagnostician. Consequently, tackling one component has implications for the other. Therefore, I will jointly discuss some solutions to these components' epistemic injustices.

Academically speaking, my thesis is relevant because, to the best of my knowledge, there is no literature proposing the subdivision of the diagnostic process into components to further identify epistemic injustice as how I present it. My work is essential socially because it argues for increased patient participation and shared-decision making, specifically during the diagnostic process.

Chapter 1: Epistemic injustice as a theoretical framework

In this chapter, I will briefly discuss the diagnostic process and motivate why the theory of epistemic injustice provides the appropriate theoretical framework to aid in the search for a more ethical diagnostic process. A better understanding of the theoretical framework of epistemic injustice is needed as it will be used in the subsequent chapters when applied to the various components of the diagnostic process in practice.

1.1 The diagnostic process

When conducting a diagnostic process, the central goal of diagnosis is procuring a detailed and explicit overview of a patient's behavior and symptoms. Trained diagnosticians, often therapists or psychiatrists, listen and take notes of the patient's testimony while observing the patient's verbal and non-verbal communication. The latter varies widely from, for example, communication and expression style, intonation, and mannerisms to fidgeting or blinking. In addition, patients are interviewed about essential parts of their life deemed relevant to understand the patient, including current living situations, family situations and childhood, mental and physical health history etc (King, 2022). This process usually spans multiple sessions, and at the end, a diagnosis is concluded and shared with the patient. During this conversation, the choice for the diagnosis and its implications for therapy are explained.

The diagnostic process is analyzed by its division into three separate components:

- 1) The testimony that the patient is giving, both verbally and non-verbally
- 2) The diagnostician's observation of the patient and conclusion of the testimony that the patient is giving
- 3) Diagnostic criteria that help reduce the patient's symptoms and categorize them into a diagnosis

These three components are needed to formulate a diagnosis. Each of these components is a source of information and knowledge. The first component regards the patient's provision of information- it encompasses the information's content and the form in which this information is given. On the one hand, it addresses information that is told. On the contrary, as I will argue in chapter 2, it also addresses information that is withheld. The second component relies solely on

the observation and thought processes of the diagnostician. It regards the diagnostician's understanding of the content of patient testimony, how they interpret the patient's words, their observations, and the conclusions they draw from having witnessed a patient's testimony. The conclusion rests on the expert knowledge that the diagnostician possesses. The third component regards the diagnostic criteria used to help categorize symptoms into a diagnosis. These criteria are an additional source of information whereby expert knowledge by diagnosticians is thought to be required to use these criteria. In short, the diagnostic process requires multiple sources of information and knowledge. An additional crucial factor facilitating this transaction of information and knowledge is the relationship between the patient and the diagnostician. I will argue in chapter 3 that an imbalance in power and knowledge between patient and diagnostician may also lead to epistemic injustices.

Having demarcated the three components of the diagnostic process and having recognized that transactions of information and knowledge are requirements for the diagnostic process, it can easily be imagined how these various sources of information and knowledge ought to be carefully balanced. If they are not dealt with care and caution, there is a risk of generating an inaccurate conclusion of the diagnostician, resulting in an inaccurate or misdiagnosis. Not only is this outcome inaccurate and harmful to the patient, but I will also argue that it is a matter of epistemic injustice.

1.2 Epistemic injustice

In the following section, I will address the theoretical framework I will be using and its relevance to the psychiatric field. Epistemology is the theory of knowledge. The Stanford Encyclopedia writes: "The term "epistemology" comes from the Greek words "episteme" and "logos". "Episteme" can be translated as "knowledge" or "understanding" or "acquaintance", while "logos" can be translated as "account" or "argument" or "reason"." (Steup & Ram, 2020). Due to the subject we are discussing, imbalances in both knowledge and power, a well-suited piece of literature "Epistemic Injustice - *Power and the ethics of knowing*" by Miranda Fricker will help us identify epistemic injustice during the diagnostic process in psychiatry specifically. Epistemic injustice, as a concept from her theory, has been widely used in the medical field to identify

various accounts of epistemic injustice between patients and physicians. However, I believe it to be conducive, specifically regarding the various components of the diagnostic process.

Fricker speaks about how epistemic injustice can be used as a concept to identify the normalcy of injustices (2007). She speaks on how injustices occur in everyday life and how society fails to recognize everyday actions as injustices or everyday interactions as unjust (Fricker, 2007). Because the diagnostic process in psychiatry is a daily practice, and patient knowledge has been excluded for as long as we conceptualize psychiatry, the diagnostic process is a perfect social situation to apply her theory.

1.3 Epistemic injustice as proposed by Fricker

Epistemic injustice is a concept of a theory wherein ethics and epistemology conflate. While Fricker argues the purely epistemic nature of her theory, it explicitly addresses injustices against people in society due to societal discrimination, prejudices among social groups, and imbalances in power.

She writes about social situations where a particular *epistemic* injustice arises (Fricker, 2007). In these social situations, she distinguishes two different roles- the roles of both a speaker and a knower.

Fricker first introduced the concept of epistemic injustice to refer to “a wrong done to someone specifically in their capacity as a knower” (Fricker, 2007, p.1).

She therein further distinguishes testimonial versus hermeneutical injustice. Testimonial injustice occurs when the testimony of a person is given less credibility than she deserves due to a stereotype of the social group to which she belongs (Fricker, 2007, p.30). A simple example taken from practice would be that “people from lower socio-economic backgrounds are unintelligent”, or “people with mental health disorders are crazy.”. The prejudice that a hearer may have towards a social group that the speaker belongs to may hinder the hearer from fairly assessing the testimony that the speaker is giving them. According to Fricker, these false prejudices by hearers against speakers from marginalized social groups prevent speakers from participating in an exchange of knowledge because they are not regarded as bringers of

knowledge or informants (Fricker, 2007). A recurring example in her book is when the police do not believe someone because they are of race (Fricker, 2007).

In addition to testimonial injustice, Fricker identifies hermeneutical injustice as: “stemming from a gap in collective hermeneutical resources- a gap, that is, in our shared tools of social interpretation-where it is no accident that the cognitive disadvantage created by this gap impinges unequally on different social groups” (Fricker, 2007, p.6). Translated into more straightforward language, I understand hermeneutical injustice as an injustice experienced by speakers due to not priorly having engaged in an exchange of knowledge in such a way that they are unable to properly comprehend or articulate their own experiences, rendering them misunderstood and unintelligible by hearers. My understanding of hermeneutical injustice is that individuals go through experiences, but only after engaging in conversations or reading does one gain a form of comprehension- a post-experience realization of what exactly occurred at that moment. Through engagement in social practice, one gains vocabulary and articulacy in vocalizing and describing her experiences and thereby gains knowledge.

Fricker’s theory of epistemic injustice has been widely used in healthcare to address the specific type of relationship between patient and healthcare professional, which leads to epistemic injustice in the consultation room (Kidd & Carel, 2017). Patients often feel that their testimony is not taken seriously or that physicians draw their conclusions without adequately consulting the patient’s opinion. Physicians, contrarily, say that patients often provide irrelevant information, are too emotional, or have demands that rest on wrongful assumptions about their illness (Kidd & Carel, 2017, p.173). Patient testimonies are not thought to have epistemic value, and patient knowledge is excluded. In the interaction above, both testimonial and hermeneutical injustice occur.

1.4 The effects of epistemic injustice in psychiatry

As epistemic injustice is a form of injustice, there are various reasons to address it. However, additional reasons to address it are its harmful effects. In the next section, I will briefly elaborate on the short- and long-term harmful effects of epistemic injustice in psychiatry.

The diagnostic process uses an abundance of language and reflection. It requires a patient to assess their symptoms and articulate them in relevant and comprehensible language to the diagnostician. As I will argue later, a direct consequence of epistemic injustice in psychiatry is that the observation and conclusion of the diagnostician may be ill-informed due to the lack of inclusion of patient knowledge. Patient knowledge is increasingly recognized as relevant information (Dings, 2022). If patient knowledge is excluded, relevant information does not reach the diagnostician. If the diagnostician after that concludes a diagnosis without having included patient knowledge, then the chosen diagnosis may be inaccurate. Thus, the exclusion of patient knowledge may lead to an incorrect assessment of a patient's symptoms, ultimately resulting in an inaccurate observation and conclusion by the diagnostician and, as a result, an inaccurate diagnosis.

It follows that patients are misdiagnosed on an individual level. Misdiagnosed refers to the situation wherein a patient receives an “ incorrect, inaccurate, or incomplete identification of a disease or disorder”.(American Psychological Association, 2022) This may result in a patient not receiving a diagnosis while meeting the diagnostic criteria for that mental disorder. The implications of these are harmful to various extent for various reasons, e.g., withheld access to proper mental healthcare and inappropriate treatment. In bipolar disorder some effects of misdiagnoses are, for example, social impairments, substance abuse and suicidal behavior (Nasrallah, 2015).

Additionally, if inaccurate diagnoses occur structurally, it may result in an entire social group not receiving the mental healthcare that they need. Patients from disadvantaged social groups may increasingly have their knowledge questioned due to prejudices and biases by diagnosticians towards social groups that these patients belong to compared to patients from, e.g., higher social-economic backgrounds. Suppose patient knowledge from individuals from those disadvantaged social groups is structurally questioned. In that case, it follows that the observation and conclusion of the diagnostician may structurally be an inaccurate representation of the patient's symptoms.

It thus may be assumed that these individuals are structurally misdiagnosed as a result. One can imagine how individuals from structurally disadvantaged social groups may experience mental

health care as inaccessible. These negative individual experiences may discourage other individuals from the same social group from actively seeking mental healthcare, leading to an entire social group not seeking help. Fricker writes how the structural exclusion of a social group from engaging in meaning-making experiences, such as seeking mental health care, may lead to identity problems and prevent individuals from those social groups from becoming who they are (Fricker, 2007, p. 53-54).

In the past introductory chapter, I briefly explained the diagnostic process and elucidated the need for epistemic injustice as a theoretical framework in my thesis. Having discussed epistemic injustice as a theory regarding an imbalance in power and knowledge in social interactions, I will next hold space to address epistemic injustice in psychiatry. The following chapters will consecutively discuss the three components and identify epistemic injustice within them. Each chapter is structured similarly, wherein I first identify the manifestation of epistemic injustice, followed by a morally justified alternative, and defend it against objections.

Chapter 2: Patient Testimony

In the following chapter, I will discuss the first component of the diagnostic process: patient testimony. Patient testimony specifically regards the testimony that the patient is giving, both verbally and non-verbally. As mentioned before, a specific form of epistemic injustice, testimonial injustice, occurs when the testimony of a person is given less credibility than she deserves due to a stereotype of the social group to which she belongs (Fricker, 2007). I will be identifying various accounts of epistemic injustice during this specific component, thereby focusing on testimonial quieting and testimonial smothering, whereafter, I propose a solution to testimonial smothering. As testimonial quieting follows from the diagnostician's prejudices and implicit biases, I will discuss it in chapter 3 when identifying epistemic injustices during the second component; observation and conclusion by the diagnostician.

2.1 Testimonial injustice during patient testimony

Testimonial injustice occurs when the testimony of a person is given less credibility than she deserves due to a stereotype of the social group to which she belongs (Fricker, 2007). A simple example taken from practice would be that “people from lower socio-economic backgrounds are unintelligent”, or “people with mental health disorders are crazy”. The prejudice a hearer may have towards a social group the speaker belongs to may hinder the hearer from fairly assessing the testimony the speaker is giving. During the diagnostic process, the testimony that a patient is giving may thus be dismissed unfairly due to it not being regarded as having epistemic value as a consequence of the hearer's bias towards the social group to which the speaker belongs.

Individuals with mental disorders can be subjected to testimonial injustice in various ways. In their paper “Epistemic injustice in healthcare: a philosophical analysis”, Carel & Kidd identify several ways in which ill people are subjected to testimonial injustice (2014). One way is, for example, when patients share knowledge as speakers, but the knowledge they provide is not given attention and is not thought of as having epistemic value (Carel & Kidd, 2014, p.531). It is not simply speculation that patients cannot give their testimony as intended. Research conducted in mental health rehabilitation centers in Sweden shows how, due to time limits, efficiency, or practical circumstances, the opportunity for patients to share their testimony precisely in the way

they experienced it is impaired (Grim et al., 2019). They write: “Many users noted how important aspects of their life stories, social lives and strengths and weaknesses remained unexpressed or were lost in communication because time conditions and formats to collect information did not allow for such testimonies.” (Grim et al., 2019, p.165). Indeed, efficiency ideals often pursued within healthcare may contribute to patients not having their testimony correctly heard. In addition, I believe the diagnostician's underlying prejudice towards the patient contributes to these incomplete testimonies.

Mental health professionals use their senses to observe behavior and listen to testimonies. As testimonies and behaviors cannot be quantified and observed objectively, the work of diagnosticians is particularly susceptible to implicit biases, explaining the thorough training of mental health professionals in the field of biases (Sukhera & Watling, 2018; see also Nakash & Saguy, 2015). They are presumed to be aware of their preconceptions regarding various individuals and the different ethnic or social groups to which they belong. Research on implicit biases in mental health organizations in the Netherlands remains to be conducted. However, systematic review studies of empirical literature showed that despite careful and professional training in the field of implicit biases, the rate of implicit biases among mental health professionals remains high in the United States (Merino et al., 2018; see also Fitzgerald & Hurst, 2017). Merino et al. write:

“Even with standardized diagnostic criteria in the DSM-5, providers of mental health services are more likely to underdiagnose affective disorders and overdiagnose psychotic disorders among patients from marginalized groups compared with the majority (Nakash & Saguy, 2015). With misdiagnosis comes the likelihood that mental health professionals will fail to refer patients to the appropriate health care professionals or will inadvertently withhold treatment.”(Merino et al., 2018, p.724)

Testimonial injustice happens to people who are regularly stereotyped and put in social positions where they are not given the opportunity to voice their opinions about various issues. A prime example of testimonial injustice in a regularly stereotyped group is a person from a disadvantaged social group who seeks help regarding their mental health. People who deal with mental health issues but have not yet searched for help often struggle with multiple facets of life.

By the time they look for help, they will probably have encountered many situations wherein they have been judged and mistreated, felt misunderstood, or lost relationships due to certain expressed behaviors.

The circumstances of belonging to a marginalized group expose individuals to rougher life situations wherein they are, for example, discriminated against, live in poverty, are unemployed, or are exposed to drug abuse or other traumatic experiences that may increase the likelihood of developing a mental disorder (Reiss et al., 2019; see also Hudson, 2005; Miech et al., 1999; Reijneveld & Schene, 1998). They are more likely to have been exposed to wrongdoing by authorities, making them hesitant to seek help (Doan et al., 2020). People from marginalized groups may, consequently, be more precarious in how they are perceived and in their testimony.

Kristie Dotson writes on the reciprocity of a linguistic exchange and how that relates to testimonial injustice. She writes:

“Every speaker needs certain kinds of reciprocity for successful linguistic exchanges. Speakers are vulnerable in linguistic exchanges because an audience may or may not meet the linguistic needs of a given speaker in a given exchange.” (Dotson, 2011, p.238)

She further writes:

“In short, to communicate, we all need an audience willing and capable of hearing us. The extent to which entire populations of people can be denied this kind of linguistic reciprocation as a matter of course institutes epistemic violence.” (Dotson, 2011, p.238)

She further illustrates two subtypes of testimonial injustice- testimonial smothering and testimonial quieting. Testimonial smothering, I believe, occurs during patient testimony. Testimonial quieting, however, I believe occurs during the observation and conclusion of the diagnostician and thus will be discussed in chapter 3.

According to Fricker's conceptualization of testimonial injustice, a hearer ascribes a deflated level of credibility to the speaker's testimony due to the prejudice of the hearer towards the social group to which the speaker belongs (2007). This conceptualization rests on actions by the hearer, the diagnostician. However, it does not consider the patient's self-silencing behavior, or

withholding information that may lead to inaccurate patient testimony. Kristie Dotson's conceptualization of testimonial smothering is thus preferred.

2.2 Testimonial smothering

As explained by Dotson, testimonial smothering occurs when a speaker self-silences because she believes her testimony will be misinterpreted (2011). Dotson explains testimonial smothering by identifying and explaining three circumstances that routinely exist when testimonial smothering occurs. She writes:

“The three circumstances are: 1) the content of the testimony must be unsafe and risky; 2) the audience must demonstrate testimonial incompetence with respect to the content of the testimony to the speaker; and 3) testimonial incompetence must follow from, or appear to follow from, pernicious ignorance. As a result of these three circumstances, a speaker "smothers" his/her own testimony.” (Dotson, 2011, p.244)

On an individual level, it might not be that the hearer has acted in a way that suggests to the speaker that they will not be listened to. But it can be easily imagined how, based on their past experiences, speakers will assume that the hearer will interpret their testimony in a different way than they intended. Thus, resulting in their self-silencing behavior. A person can avoid being misinterpreted in a situation by remaining silent.

Dotson writes about black domestic violence victims in the United States who are reluctant to come forth because they do not wish to reinforce the stereotype that black men are violent by sharing their experiences (2011, p.244-245). Dotson originally wrote the conception of testimonial smothering as occurring in black individuals in the United States. I think that however different this example is from psychiatry, an analogy exists between the two situations, leading me to believe that testimonial smothering takes place during patient testimony during the diagnostic process in psychiatry. Firstly, both situations regard members of marginalized groups, who are often prejudiced and discriminated against. Individuals of both groups have often experienced their testimony being questioned and have endured unpleasant social encounters that have disadvantaged them and may have harmed them. They are both likely to assume that hearers will not interpret their testimony as they intended.

Additionally, these individuals might fear that by giving their testimony, they might reinforce the stereotype often associated with their social group. In black domestic violence, women do not want to reinforce the stereotype that black men are violent. Similarly, in psychiatric care, individuals might assume that the diagnostician will label them as emotional, irrational, and crazy. This results in their self-silencing, which is precisely what testimonial smothering entails.

Some might object that testimonial smothering and self-silencing behavior has everything to do with structural injustices and very little with the actual actions in the consultation room. I believe this claim to be false. The actions of the diagnostician in the consultation room play a crucial role in whether a patient engages in self-silencing behavior. Testimonial smothering is in no way related to the intentionality of the action resulting in testimonial smothering. We can discern intentional epistemic injustice from unintentional epistemic injustice. I will illustrate this by using the following example. A person might display subtle behaviors, for example, avoiding eye contact and suggesting that they don't trust someone else due to implicit bias, which could lead to testimonial smothering. Empirical findings suggest that implicit bias can lead people to, e.g., avoid eye contact with members of certain social groups (Hansen et al., 2015). This behavior may indicate to the person whose eye contact has been avoided that they will not be listened to (Hietanen, 2018). As a result, individuals may choose not to speak because they might judge that their audience is not receptive. Thus, an unintentional and implicit bias may lead to self-silencing behavior, thus testimonial smothering.

In the next section, I will identify a different form of epistemic injustice during patient testimony: hermeneutical injustice.

2.3 Hermeneutical injustice during patient testimony

As I have previously discussed, hermeneutical injustice is understood as an injustice experienced by speakers due to not priorly having engaged in an exchange of knowledge, in such a way that they are unable to comprehend or articulate their own experiences properly, rendering them misunderstood and unintelligible by hearers (Fricker, 2007). Kidd & Carel have built upon

Fricker's notion of hermeneutical injustice and have further proposed two terms crucial to understanding how hermeneutical injustice occurs.

The first is *inarticulacy*, which they describe as “the difficulty of adequately communicating, sharing, or ‘getting across’ certain aspects of the experience of illness” (Kidd & Carel, 2017, p.14). In medicine, inarticulacy describes the inability to explain what it means to be ill. Kidd & Carel use the example of patients inclined to resort to poetry or other art forms to help convey the “feeling of illness” (2017, p.14). When thinking of an example in psychiatry, one could imagine trying to explain a feeling while simultaneously being limited in their expression due to having poor vocabulary skills regarding emotions. For example, in patients with ADHD, a feeling of mental paralysis is often described. The patient may be perceived as coming to nothing, not undertaking or achieving anything throughout the day despite having a tight-knit schedule. The feeling of having plenty to do is often accompanied by feeling overwhelmed and anxious, resulting in unexecuted tasks (Queens, 2022). Patients are inclined to feel guilt and shame regarding their inaction and describe themselves as lazy. However, using “lazy” in this situation would be the incorrect term, as patients often better describe this feeling as “mental paralysis” (Queens, 2022). However, they may lack the vocabulary, and thus hermeneutical resources, to describe what they are experiencing. This lack of hermeneutical resources is often, if not always, present during the diagnostic process. Patients are experiencing symptoms and seeking to get better. However, during this phase, patients usually have little understanding of their symptoms and do not possess the vocabulary to articulate their feelings appropriately. They cannot find the right words (Kidd & Carel, 2018, p.222).

The second form of hermeneutical injustice is *ineffability*, about which Kidd & Carel write: “...the sense that certain aspects of those experiences cannot be adequately communicated to others through propositional articulation at all because understanding is premised upon a person's having had the requisite bodily experiences” (Kidd & Carel, 2017, p.14). They use examples of going through childbirth, experiencing violent military conflict, or religious experiences (Kidd & Carel, 2017, p.14). In other words, experiences would be nearly impossible to explain to someone who has not had the same experiences because exclusively using words would be insufficient when trying to have somebody understand you in the way you intend. The

hearer would not be able to imagine the experience because it is so unique that words cannot explain it to someone who has not had that same experience. Some examples of ineffability in psychiatry may be: going through psychosis, experiencing hallucinations or depression, suffering from paranoid thoughts, or experiencing suicidality. These experiences may be experienced as incommunicable by patients, and one's understanding of a patient's symptoms would rest on the diagnostician having lived through the same experience.

A simple example wherein both patient and diagnostician share similar experiences is, for example, a patient with executive dysfunction, meaning experiencing difficulty completing tasks, lack of concentration, and feelings of shame and guilt. Those are several symptoms of Attention-Deficit-Hyperactivity-Disorder (ADHD), the most common mental disorder diagnosed worldwide (American Psychiatric Association (APA), 2022). Due to this diagnosis being so common, a scenario wherein the psychiatrist also has ADHD is a realistic possibility. In this scenario, if a patient were to name their symptoms, the psychiatrist would recognize the symptoms from not only the diagnostic criteria, but also personal experience and having lived through that experience. Similar examples are, for example, patients suffering from symptoms often associated with depression, anxiety, an eating disorder, or PTSD. But in reality, almost all mental disorders are debilitating disorders that everybody in society can experience.

A critical remark is that experiencing the same event does not solve ineffability. Various persons could live through similar events but experience the same situation differently. For example, multiple military soldiers could all be living through a potentially traumatic event; however, one individual develops symptoms of post-traumatic stress disorder (PTSD), while the other does not (Xue et al., 2015). Thus, ineffability does not simply describe experiencing an event but also hints at some emotional experience that ought to be similar in both individuals to understand each other truly. One can think of how two children raised by the same parents but two years apart might have different experiences and diverging childhood memories. The events they attended might have been the same. Still, there would have been multiple factors, among other things, different personalities and relationships with their parents, due to which experiences may differ (Daniels & Plomin, 1985). Some emotions might thus be experienced similarly, resolving ineffability, while in other experiences, ineffability will persist. If the patient and diagnostician

have experienced similar events and also experienced them similarly, then ineffability might be relieved.

In short, I have identified hermeneutical injustice during patient testimony based on inarticulacy and ineffability and discussed how ineffability might be overcome.

2.4 An ethically justified alternative

Having identified testimonial smothering and hermeneutical injustice during patient testimony, I will think of an ethically justified alternative to testimonial smothering in the following section. I will consider Fricker's notion of testimonial justice, argue that it is partly applicable, and instead propose a practical approach as a corrective to testimonial smothering. I briefly introduce Fricker's notion of hermeneutical justice to address hermeneutical injustice. Still, due to its mutual interrelation with the second component: the observation and conclusion of the diagnostician, I will discuss it further in chapter 3.

2.4.1 Testimonial justice

In section 2.1, I have identified the presence of testimonial smothering during patient testimony as conceptualized by Dotson. Dotson's conceptualization proves fruitful in identifying self-silencing behavior by clarifying the socio-epistemic circumstances that give rise to epistemic injustices. Unfortunately, it does not provide a normative stance to combat it best, leading me to resort to the original conceptualization of testimonial justice proposed by Fricker.

Fricker's conceptualization of testimonial justice rests on virtue ethics as follows from her ideal to strive for by a virtuous hearer (2007). It requires the hearer to adopt an anti-prejudicial virtue that can be developed by structurally reflecting on one's identity and social position in relation to the speaker's identity and social position (Fricker, 2007, p.91). According to Fricker, structurally reflecting on one's identity and social circumstances may neutralize any "impact of prejudice in her credibility judgements" (Fricker, 2007, p.92). Testimonial justice thus is achieved when knowledge is shared between the speaker and the hearer unimpeded by prejudices or biases by the hearer, whereby a just attribution of credibility of the speaker's testimony is guaranteed.

While this form of testimonial justice might prove fruitful when addressing biases, it presupposes the presence of prejudices.

We can conclude that Fricker's notion of testimonial justice can only partly be used as a corrective to testimonial smothering by patients. According to Fricker, it follows that by adopting the role of a virtuous hearer, the diagnostician ought to correct their prejudices and biases (2007). As a result hereof, testimonial justice would be achieved. However, this concept does not translate fully to self-silencing behavior, as self-silencing is not directly a result of prejudices by the diagnostician. I will explain why.

I have discussed earlier that implicit biases may result in unintentional acts by diagnosticians that may cause patients to self-silence. Unintentional acts by the diagnostician, for example, not making appropriate eye contact, may strengthen a patient's conviction that the diagnostician will not understand their testimony in the way they intend. In this case, striving for testimonial justice, as proposed by Fricker, is an effective corrective against unintentional epistemic injustice.

However, unintentional epistemic injustice is not the leading cause of self-silencing behavior. Having identified earlier that testimonial smothering results from being structurally prejudiced against, it thus cannot be imagined how a diagnostician's adoption of the role of a virtuous hearer by correcting for their prejudices may prove sufficient to empower a patient to speak up instead of staying quiet. Striving for testimonial justice using Fricker's conceptualization thus proves effective only partly.

Testimonial smothering, as we have applied to the diagnostic process, entails self-silencing behavior by the patient to prevent them from being improperly understood by the diagnostician. The very nature of testimonial smothering is that individuals stay silent to prevent something bad from happening. The patient self-silences not because the diagnostician has shown a particular act or the omission of an act but because the patient associates speaking up with harm that may follow. A specific risk to speaking up can be prevented by staying silent. Testimonial smothering occurs as a result of multiple prior incidents of structural oppression and being prejudiced against

(Dotson, 2011). Three key features can be identified in testimonial smothering. The first is that patients withhold patient knowledge, the second is that there is a risk to sharing knowledge, and the third is that it follows from a structural problem. A lasting solution ought to address these three key features. Solutionizing the third feature would entail solving structural marginalization and prejudice against individuals from certain social groups, which seems unattainable in practice.

A more practical solution to combating testimonial smothering would entail mitigating against self-silencing behavior by addressing its first and second key features. I believe that the prevention of self-silencing behavior may thus need to comply with the following three conditions:

1. Self-silencing behavior ought to be discouraged.
2. Speaking up ought to be encouraged.
3. The bond between patient and diagnostician ought to be strengthened.
4. Safety ought to be harbored

Self-silencing behavior should be discouraged, and the contrary should be encouraged, while strengthening the bond between patient and diagnostician and harboring safety. To encourage speaking up and discourage self-silencing behavior, I propose that empowering tactics should be implemented during the diagnostic process.

According to the World Health Organization (WHO), empowerment on an individual level means:

“...overcoming a state of powerlessness and gaining control of one’s life. The process starts with individually defined needs and ambitions and focuses on the development of capacities and resources that support it. The empowerment of individuals is intended to help them adopt self-determination and autonomy, exert more influence on social and political decision-making processes and gain increased self-esteem.” (WHO, 2010, p.1)

Due to a lack of space, I will not discuss a concrete analysis or implementation of empowering tactics during the diagnostic process. However, according to the WHO, empowerment starts with

the development of capacities. An approach worthy of consideration regarding the development of capacities may be the capabilities approach. The details on which actions to implement within the consultation room to help a patient feel more empowered to prevent engaging in self-silencing acts require further research. However, the aim of empowering tactics is to encourage the patient to speak up in such a way that they contribute patient knowledge, and their testimony accurately represents their symptoms.

Having concluded empowering tactics as a solution to testimonial smothering during patient testimony, I still ought to address the solution to hermeneutical injustice. I have identified hermeneutical injustice by the concepts of inarticulacy and ineffability of the patient. While this injustice applies to patient testimony, it ultimately influences the diagnostician's observation and conclusion, leading to an inaccurate assessment of patient testimony. However, these components are interrelated and influence each other continuously. Therefore, I will address its solution in the next chapter when analyzing the observation and conclusion of the diagnostician.

2.5 Recap chapter 2

In this chapter, I have discussed patient testimony as the first component of the diagnostic process and identified the presence of self-silencing behavior by patients using Dotson's conceptualization of testimonial smothering. Solutions targeting self-silencing behavior rest on empowering tactics during patient testimony.

Chapter 3: The diagnostician's observation and conclusion of patient testimony

In this chapter, I will focus on the diagnostic process's second component: the diagnostician's observation and conclusion of patient testimony. I will discuss how testimonial and hermeneutical injustice arise due to implicitly held beliefs by the diagnostician and patients' lack of resources to render themselves intelligible. These biases and unintelligibility lead to wrongful conclusions by the diagnostician and harm. I will discuss the difficulty of truly solving the root causes of these wrongful conclusions and explain how they are unpreventable. Therefore, my proposed solution will rest on a shift in power dynamics between patient and diagnostician and simultaneously tackle testimonial and hermeneutical injustice. First, I will discuss the importance of expert knowledge in formulating diagnoses.

3.1 Expert knowledge and training

In this thesis, I have discussed the role of diagnosticians. Diagnosticians are always clinical psychologists or psychiatrists. Psychiatry is “the branch of medicine that deals with the causation, prevention, diagnosis and treatment of mental and behavioral disorders.” (Trivedi & Goel, 2006). After finishing medical school, physicians can choose to specialize in psychiatry. Similarly, graduated psychology students can enroll in clinical psychology. In the Netherlands, this requires an additional five years of studies and training in the human psyche, behaviors, and mental disorders to become a psychiatrist or clinical psychologist and, thus, a diagnostician. They learn about the etiology of mental disorders, their development, and their treatment through psychotherapy and drug therapy. Diagnosticians are trained to use their minds and senses to observe symptoms of mental disorders in patients. Next to studies about mental disorders, they are trained in who they are as individuals, how their personality is formed, and how to diagnose patients free of their convictions. They are trained to beware of their implicit biases towards individuals so that their “diagnostician view” can be objective and separate from their own belief system. Only diagnosticians possess the expertise and are licensed to attribute a mental disorder diagnosis to a patient.

3.2 Implicit beliefs of the diagnostician leading to testimonial injustice

A diagnostician's work remains prone to human error despite being trained to make diagnoses free of individually held prejudices and biases towards certain social groups (Nakash & Saguy, 2015). In this section, I will discuss how a diagnostician may hold negative implicit beliefs and associate them with patients from a specific social group. These implicitly held beliefs may lead to the exclusion of patient knowledge, which is epistemic injustice. Additionally, it may result in inaccurate conclusions during the diagnostic process. We have already discussed in chapter 1 how harmful effects follow from the exclusion of patient knowledge.

What exactly is implicit bias? For the definition of implicit bias, I will use the conception formulated by Jules Holroyd. She writes: “An individual harbors an implicit bias against some stigmatized group (G), when she has automatic cognitive or affective associations between (her concept of) G and some negative property (P) or stereotypic trait (T), which are accessible and can be operative in influencing judgment and behavior without the conscious awareness of the agent.” (Holroyd, 2012, p.274).

In simpler terms, implicit biases are biases held by our subconscious. To gain a further understanding of implicit biases, Holroyd demarcates three elements crucial to its conceptualization. She first distinguishes explicitly held beliefs from implicitly held beliefs and exemplifies this by stating the following: “an agent could explicitly entertain nonprejudiced thoughts about a member of a stigmatized group while unconsciously making cognitive associations with negative evaluations or stereotypic traits; she might then be described as having implicit negative attitudes or biases” (Holroyd, 2012, p.275). This is important because an individual may voice explicitly feminist views and thoughts, while implicitly harboring internalized misogynistic beliefs.

Secondly, she distinguishes implicitly held beliefs from the actions influenced by these beliefs. One might harbor implicit views about social groups, but these beliefs may not influence their actions. The third element of implicit bias revolves around its unconscious nature. She states: “...the associations in question are automatic, occurring without the instigation of the process

being consciously directed or undertaken, and not directly subject to rational revision in the way our explicit beliefs are.” (Holroyd, 2012, p.275). In short, explicitly held beliefs do not equal implicitly held beliefs, having implicit biases does not equal that these implicitly held beliefs influence actions, and thirdly, these implicitly held beliefs exist in our subconscious, free from rational considerations. Having identified implicitly held beliefs by diagnosticians, it can further be argued how they may lead to testimonial injustice.

3.2.1 Testimonial injustice

Having used Dotson’s conceptualization of testimonial smothering to identify testimonial injustice during patient testimony, an additional form of testimonial injustice, namely testimonial quieting, occurs during the observation and conclusion of the diagnostician. I will elucidate how this follows from implicit biases by the diagnostician.

Testimonial quieting occurs when an audience fails to identify a speaker as a knower. As discussed in chapter 2, Dotson uses the example of black women in the United States of America who are often identified as not being knowers because of the stereotypes associated with them. As a result, when they try to speak and articulate their experiences, hearers can fail to take in their testimony and respond appropriately. Testimonial quieting thus occurs due to a false stereotype - the false stereotype that black women are not knowers. Dotson goes on to explain how this can damage the intellectual courage of systematically silenced individuals. One can imagine when all members of a specific group are systematically silenced in this way, the knowledge within that group, for example, knowledge within their intellectual traditions, is lost. They cannot articulate their experiences and have the information received by other people. According to Dotson’s conceptualization, testimonial quieting is similar to the more general account of testimonial injustice described by Miranda Fricker. A hearer ascribes a deflated credibility level to the speaker’s testimony due to a hearer’s prejudice towards the social group to which the speaker belongs. Suppose the content of patient testimonies remains unchanged, but the diagnostician’s conclusion of patient testimony differs between patients from different social groups. In that case, the diagnostician may harbor some prejudice towards a patient. This means that a diagnostician’s conclusion of the patient’s testimony may be influenced by a factor unbeknownst to the psychiatrist themselves due to implicit biases’ subconscious nature. It also

means that valuable patient knowledge crucial to correctly understanding a patient's testimony is lost.

3.3 Hermeneutical injustice during observation and conclusion of the diagnostician

In addition to testimonial injustice, hermeneutical injustice also plays a role in the diagnostician's observation and conclusion of patient testimony. Hermeneutical injustice regards a gap in collective resources that disadvantage the speaker, rendering them unintelligible to the hearer. I have already discussed in section 2.3 how this occurs due to inarticulacy and ineffability. Patients' testimonies, therefore, might not accurately represent their symptoms. They will, by default, influence the observation and conclusion made by the diagnostician. For example, if a speaker lacks the vocabulary to express their experiences clearly, then the hearer may improperly understand patient testimony. The diagnostician's observation and conclusion of patient testimony will also differ.

This occurs, for example, in the case a patient uses slang to describe certain phenomena due to a lack of jargon. When patients explain their symptoms and experiences in slang, hearers might misunderstand them, resulting in inaccurate conclusions by the diagnostician. Hermeneutical injustice thus occurs due to the structural impoverishment of collective resources among patients.

So far, I have identified two problems with the observation and conclusion of the diagnostician. First, testimonial injustice may arise due to the diagnostician's implicitly held associations with certain social groups. Secondly, diagnosticians may incorrectly understand patient testimony due to patients lacking the hermeneutical resources to render themselves intelligible, leading to an inaccurate observation and conclusion by the diagnostician. When the conclusion of the diagnostician leads to misdiagnoses among patients, then patients are being harmed.

3.4 Epistemic justice as a corrective means

The key to solving epistemic injustice in the component of observation and conclusion of the diagnostician thus rests on solving both testimonial injustice, specifically testimonial quieting, and hermeneutical injustice. When implementing Fricker's notion of testimonial and hermeneutical justice, we encounter problems regarding both.

3.4.1 Testimonial justice

Firstly, as discussed in chapter 2, testimonial justice, as conceptualized by Fricker, requires the hearer to adopt an anti-prejudicial virtue that can be developed by structurally reflecting on one's own identity and position in society in relation to the speaker's identity and position in society (Fricker, 2007, p.91). Testimonial justice thus is achieved when knowledge is shared between the speaker and the hearer unimpeded by prejudices or biases by the hearer, whereby a just attribution of credibility of the speaker's testimony is guaranteed. When applied to the diagnostic process, it aims to correct implicit biases among diagnosticians so that their observations and conclusions are prevented from being influenced by their implicitly held biases.

However, this poses an issue as these implicit biases persist among diagnosticians despite being thoroughly trained in their awareness of biases. A speculative reason could be due to the subconscious nature of implicit biases. However, this poses the following question: How will individuals correct for actions influenced by implicitly held beliefs and associations they are unaware of? Unfortunately, Fricker's notion of testimonial justice does not consider the implicit nature of implicitly held biases and prejudices of individuals (Fricker, 2007, p.87-91). Holroyd's analysis of the nature of implicit biases thus seems to dismiss Fricker's ideal of correcting for them, as their implicit nature thus prevents rational consideration and reflection of these biases. Having concluded that Fricker's notion of testimonial justice proves unsuccessful in achieving testimonial justice, I will consider whether her notion of hermeneutical justice proves fruitful.

3.4.2 Hermeneutical justice

Having identified hermeneutical injustice based on inarticulacy and ineffability in section 2.3, I will follow Fricker's suggestion to reach hermeneutical justice in the next section. She states the following:

"The hermeneutically virtuous hearer is reliably successful in achieving the end of a psychologically entrenched motivation: namely, the motivation to make his credibility judgment reflect the fact that the speaker's efforts to make herself intelligible are objectively handicapped by structural identity prejudice in the collective hermeneutical resource." (Fricker, 2007, p.173)

Fricker suggests that hermeneutical justice occurs when a hearer corrects for potential unintelligibility by the speaker by adopting a virtuous attitude (Fricker, 2007, p.169). In simpler terms, hermeneutical justice is achieved when individual hearers and institutions value varying ways of articulating and vocalizing experiences by speakers. In this case, I believe Fricker's suggestion may prove fruitful. While teaching patients the vocabulary to articulate their experiences better attainable in therapy, this seems impractical to achieve during the diagnostic process. We cannot expect new patients to possess the language skills to express themselves entirely effectively. A hermeneutically just stance by a virtuous hearer who adopts the attitude of "It is not your fault but mine that I am unable to understand you" (Fricker, 2007), thus seems like a desirable solution even if that solution entails, for example, trying to better understand symptoms expressed in slang language. During the diagnostic process, achieving an accurate understanding of a patient's testimony is imperative. Fricker's suggestion seems to advocate for this. A remark in this suggestion is that Fricker's suggestion of hermeneutical justice does shift additional responsibility towards the diagnostician.

So far, we have concluded two problems when proposing solutions to testimonial and hermeneutical injustice. Testimonial justice does not consider the implicit nature of implicit biases, as a result whereof, they are exempt from rational consideration and reflection. This leads us to conclude that testimonial justice, as proposed by Fricker, seems ineffective when mitigating against testimonial quieting. Contrarily, her conceptualization and recommendations regarding hermeneutical justice may seem helpful in practice, although they may shift an additional responsibility towards the diagnostician to correct for a patient's possible unintelligibility.

Considering Fricker's normative notion of testimonial and hermeneutical justice, I aim to propose a practical solution that, more than any other reason, focuses on effectivity. While epistemic injustice seems challenging to solve in practice, it thus leaves us no other option than adopting a practical approach to mitigate the harmful effects that follow from it. My proposal rests on a shift in power dynamics during the diagnostic process. To explain this approach, I will first explore the power dynamics during the diagnostic process in the following section.

3.5 Imbalances in power between patient and diagnostician

In the next section, I highlight how an imbalance in power within the relationship between patient and diagnostician leads to harm.

In the medical field, the distinct relationship between patient and physician has been widely scrutinized as being especially prone to imbalances in power (Kidd & Carel, 2017). When applied to psychiatry, the diagnostician is in the privileged position of more power, while the patient is in the position of lesser power. What I believe to be true for all patients is that they seek help, which places them in vulnerable positions, specifically in positions of lesser power. The most straightforward argument for this might rest on the fact that individuals are reluctant to seek help, even when they require it and even when it is readily accessible (Lee, 1997). Seeking aid and assistance is implicitly linked to a certain degree of helplessness, dependence, and ineptitude and is analogous to powerlessness (Lee, 1997). Even if they may not have lesser power, seeking help is linked to feeling helpless and being perceived as helpless. As individuals go to different lengths to prevent being perceived as powerless, they will not seek aid.

One of the ways an imbalance in power occurs during the diagnostic process regards *an imbalance in power of decision*, a term used to describe having no control over what will happen. During the diagnostic process, the diagnostician is in the position of having the power of decision. They can organize and adjust the setting and conversation according to their wishes. Being in charge offers freedom. This power also decides, for example, when enough information is gathered regarding a specific topic or to conclude a diagnosis (Carel & Kidd, 2014). This conclusion may leave patients astounded, as a diagnostician may terminate the information-gathering process and conclude a diagnosis while a patient may feel that the very core of symptoms and problems have not been discussed sufficiently.

Of course, many diagnosticians may ask for the patient's approval regarding the length and depth to which all topics are discussed. However, this decision's power remains in the diagnostician's hands. Whether a diagnosis will be attributed, and if so, which one solely resides in their hands. Patient participation during the diagnostic process remains uncommon. To my knowledge,

literature on this topic has yet to be written. Nonetheless, I believe patient participation could considerably contribute to solving epistemic injustice in psychiatry.

The term "*patient participation*" or "*patient involvement*" in psychiatry describes the patient's adoption of an active role (Tambuyzer et al., 2014). It symbolizes a patient's conversion from an inactive to an active participant. Tambuyzer et al. identify five key elements of patient involvement: "(i) participation in decision making, (ii) the active character of involvement, (iii) involvement in a diverse range of activities, (iv) expertise by experience, and (v) collaboration with professionals." (Tambuyzer et al., 2014, p.141). Patient involvement is often stimulated and advocated for during therapy because of its benefits (Beitinger et al., 2014; also see Hamann & Heres, 2019; Westermann & Maurer, 2015). Research in psychiatric facilities has shown that an increase in patient participation "enables person - centered care, with the benefits of collaboration, co - production and enhanced quality of care" (Wärdig et al., 2021, p.1443). A small study released questionnaires among out-patient psychiatric patients about how they view patient participation and what it would ideally look like in practice. What patient participation meant to patients was summarized as "being listened to, being in a reciprocal dialogue, learning about one's health care and managing one's symptoms" (Wärdig et al., 2021, p.1443). Additional clarifications mentioned that "including patient participation is about mutual respect and shared trust" (Wärdig et al., 2021, p.1443). These recent studies show an underlying need for patients to assume an active role in their mental health care.

3.6 Increased patient participation as corrective means

Next, I will argue how a shift in power during the decision-making process may give patients a voice during the decision-making process and help neutralize the influence of prejudices of the diagnostician on these decisions.

While in psychiatry, increased patient participation or shared decision-making is often advocated for, in practice, it is put into effect by including patients in choosing between therapy options. Patient participation remains far from practice during the diagnostic process. However, if we want to combat epistemic injustices and the misdiagnoses that, as a result, follow, I believe we ought to give patients more power during the diagnostic process. The exact numbers of

misdiagnoses in psychiatry in the Netherlands remain unknown. Psychiatry differs from general medical practice due to our lack of diagnostic measures. Phillips studied statistics on psychiatric diagnoses and error margins. The problem with psychiatry is that the diagnostic categories are formulated without measurable markers (Phillips, 2014, p.75). Diagnostic errors, and misdiagnoses in general are therefore difficult to quantify (Phillips, 2014, p.76). However, results from a Canadian cross-sectional study showed the rates of misdiagnoses to be alarming: “65.9% for major depressive disorder, 92.7% for bipolar disorder, 85.8% for panic disorder, 71.0% for generalized anxiety disorder, and 97.8% for social anxiety disorder” (Vermani, 2011, p.1). Additionally, specialized psychiatric facilities in Ethiopia revealed misdiagnoses to be nearly 40% (Ayano et al., 2021). While the accuracy of these numbers can be disputed, they illustrate how flawed our current practices of reaching a diagnosis are. The effects of these misdiagnoses are long-lasting and severely impact one’s life. On the other hand, remaining undiagnosed while meeting the criteria for diagnosis prevents individual access to increased knowledge, learning about one’s diagnosis, and tools to navigate one’s life with the help of therapy.

Active patient involvement during the diagnostic process is needed as a corrective means to prevent misdiagnoses within psychiatry. The simplest way to achieve this may be by shifting power dynamics during decision-making. Both diagnosticians and patients should have a voice in which diagnosis fits the patient best. I thus propose opening the decision-making process to patient knowledge and attributing their voice weight by giving them the power of decision throughout the diagnostic process. This increase in power manifests through, for example, the power to decide when an issue has been settled, the power to provide feedback, the power to co-decide on a diagnosis, and the power to decide whether a diagnosis is correct. I have discussed earlier in this thesis that patients with mental disorders can provide relevant information and adequately make rational decisions regarding their mental disorders. I thus propose we implement their rational decision-making capacities and initiate an alternative diagnostic process wherein patients' voices are honored and attributed more weight. I believe in shared responsibility to come to the correct diagnosis as a desirable and realistic outcome. Having discussed an alternative wherein patients were to receive more power during the diagnostic process, some objections immediately come to mind. I will discuss those in the next section.

Researchers in the field of implicit biases have hinted that implicit biases can be addressed and reduced with specific interventions. While a commonly held belief to reduce implicit biases suggests interacting with those different from you, a systematic review has found this approach to appear unsuccessful regarding short-term effects (Fitzgerald et al., 2019). Unfortunately, solid research measuring the efficacy of combating implicitly held beliefs remains to be conducted.

It has been argued that the implicitly held association is not the most significant culprit of harm, but the action that this association influences (Holroyd, 2012). To prevent actions from being influenced by implicitly held associations towards certain social groups, we ought to redesign the conclusion and choice of the diagnosis in such a way that actions influenced by the implicit beliefs of diagnosticians may be neutralized. While this sounds difficult to achieve, I believe the solution resides in a shift in power dynamics between patient and diagnostician.

3.7 Objections to patient participation during the diagnostic process

Having argued for increased patient participation during the diagnostic process, I will next discuss some objections worthy of consideration.

3.7.1 Increased responsibility

While active participation has many advantages, increased power indisputably corresponds with greater responsibility. Some might argue that not all patients can carry the burden of responsibility, especially in decision-making regarding one's mental health. Even patients themselves might argue for this. Depressed patients may suffer from a lack of energy and often struggle daily to get out of bed. It can be easily imagined how depression might generate reluctance to decide on anything, especially a mental disorder diagnosis. Thus, imagining their choice not to participate actively during this diagnostic process is easy. However challenging partaking in the decision-making process may be, the possibility of using one's power to participate in decision-making ought to remain. If patients choose to waive that power, that is their right to choose. However, I believe that the opportunity to make that choice ought to remain. It can also be the case that sometimes mentally ill persons cannot take on an active role or contribute at specific moments due to impaired judgment, as is the case in, e.g.,

mid-psychosis, mid-mania, mid-suicidality. I think that the option should remain and that also, at a later date, one may be allowed to invoke their power. If patients are unwilling to partake in decision-making, they ought to be stimulated, and if they are unable to, then the decision may be made for them.

How patient activation may be implemented in practice falls outside my field of expertise and surpasses the scope of my thesis. However, some simple tactics to increase patient participation ought to, as the bare minimum, include the following conditions:

- i) asking the patient whether they have thought of their diagnosis/whether they have an intuition of the diagnosis that they may receive or identify with
- ii) asking which symptoms patients identify with the most
- iii) involving the patient every step of the way, including the diagnostician's thought processes about their symptoms, but also involving the patient in thoughts about diagnoses and checking whether they recognize themselves in or identify with specific symptoms or a diagnosis

This is not meant to be an exhaustive list, but I solely aim to show how a shift in power dynamics might produce a more fair decision-making process and lead to a better and more accurate diagnostic process.

3.7.2 Impaired judgment

Another objection to patient participation in the diagnostic process is that mentally ill individuals are regularly seen as having specific characteristics that would disable them from good decision-making and would exclude them from this process. While this argument holds in specific situations, for example, situations wherein hallucinations and delusions are present, this argument does not hold for the majority of patients with mental disorders. Most patients diagnosed with mental disorders are competent in making rational, thought-out decisions and partaking in SDM (Grim et al., 2022). Grim et al. discuss how patients who use treatment, or as they call it, “service”, can contribute relevant information, knowledge, and opinions on, e.g., SDM (2022). They discuss the different ways in which patient knowledge is relevant and contributing. However, a cultural shift is needed for the information to be widely perceived as relevant.

3.7.3 Decision-making capacity

An additional objection rests on the argument of decision-making capacity. While there seems to be no straightforward test that assesses a patient's decision-making capacity in psychiatry, I believe that the literature on informed consent by Barstow et al. can prove helpful. They write: "Capacity is the basis of informed consent. Patients have medical decision-making capacity if they can demonstrate understanding of the situation, appreciation of the consequences of their decision, reasoning in their thought process, and if they can communicate their wishes." (Barstow, 2018, p.40). Suppose patients meet these requirements of decision-making capacity. In that case, there is no reason to exclude them from participating in the decision-making process regarding their own diagnosis.

In summary, this past chapter has discussed that implicitly held beliefs by diagnosticians may lead to testimonial injustice. Hermeneutical injustice arises due to a structural lack of resources of patients who experience difficulty articulating their experiences. Both epistemic injustices are harmful in themselves but become increasingly harmful if diagnosticians, as a result, draw wrongful conclusions. Solutions targeting the cause of these epistemic injustices may fail due to the subconscious nature of implicit biases and hermeneutical justice shifting additional responsibility towards the diagnostician. The solution I have thus proposed is a shift in power dynamics during the diagnostic process. Patients are empowered and given the power to decide on all aspects of the diagnostic process. In the next chapter, I will discuss the third and final component of the diagnostic process: diagnostic criteria and address the epistemic injustices that may arise.

Chapter 4: The diagnostic criteria

In the following chapter, I will be discussing the third and last component of the diagnostic process; the diagnostic criteria. This chapter makes two claims. First, excluding patient knowledge in formulating diagnostic criteria is a matter of epistemic injustice. Second, the exclusion of patient knowledge leads to harm. I will start by briefly discussing the most common diagnostic tool, The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V), and how epistemic injustices arise from the way diagnostic criteria are formulated in this tool. I will use Anke Bueter's identification of *pre-emptive* testimonial injustice within the diagnostic criteria, consider her suggestion to combat epistemic injustices, and argue why I believe her suggestion falls short. I will consider her arguments, possible objections and conclude that combating epistemic injustice in the diagnostic process should happen by addressing all three components by showing the concepts' interrelatedness. Hereafter, I discuss the challenges encountered when proposing an alternative free of epistemic injustices.

4.1 *The diagnostic tool*

The DSM-V is the latest edition of a diagnostic tool recognized worldwide as the golden standard for the identification and classification of mental disorders. Its first edition version dates back to 1952 and has since been revised every decade or so. There are nearly 300 mental disorders listed in the DSM-V, wherein every disorder is formulated by a set of criteria that must be met to be diagnosed with the specific disorder. The DSM-V has been a subject of criticism and skepticism for some decades. Some of this criticism regards the DSM-V's feature of distinguishing normal from pathological behavior. I will briefly mention this debate in section 4.6, when addressing the limitations of my solution.

The content of the DSM has been written and revised by mental health professionals and researchers who have worked in the diagnostic field, in other words, experts ranging from psychologists to psychiatrists in the American Psychiatric Association (APA). For the first time, the APA opened the revision process of the fifth DSM edition to public feedback, resulting in 11,000 reactions. However, when analyzing the type of feedback included in the diagnostic criteria, it predominantly regards matters of inclusivity, for example, naming the disorders to be

more inclusive such as the titling of disorders (Bueter, 2019, p.1067). In other words, the quality of the patient knowledge that has been included has regarded chiefly the context of mental disorders without addressing the content of mental disorders. Including this type of patient knowledge has led to epistemic injustice.

4.2 Epistemic injustices in the diagnostic criteria

It has been stated earlier that epistemic injustice arises due to the formulation of the diagnostic criteria. Bueter has argued how the exclusion of patients from the revision process of the DSM is a specific case of epistemic injustice- she deems it: *pre-emptive* testimonial injustice. This type of testimonial injustice differs from the testimonial injustice stated by Fricker. Fricker's account suggests hearers ascribing a deflated level of credibility to the patient's testimony, thereby wronging them in their capacity as knowers. Contrarily, Bueter's account of pre-emptive testimonial injustice rests on the fact that first-person knowledge has not been included in the diagnostic criteria *pre-emptively*. Patient knowledge is not excluded after consideration but before ever being considered. Apart from leading to epistemic injustice, this exclusion of patient knowledge is harmful because it implies that experts have judged before hearing patient knowledge that it will not significantly contribute to the diagnostic criteria. Patients are identified as not being knowers, which is a judgment based on a false stereotype- the stereotype that patients with mental disorders are not knowers. Not including patient knowledge is a classic example of how patients are disregarded as knowers and how the valuable information they can contribute is lost. This loss of patient knowledge may lead to harm.

4.3 The value of patient knowledge

Why is the exclusion of patient knowledge so harmful? In order to address harm, I will show that patient knowledge is valuable for several reasons.

Firstly, it has been argued that subjective patient knowledge is crucial for formulating diagnostic criteria in psychiatry (Flanagan, 2010, p.298-299). Subjective first-person perspectives of mental disorders could provide valuable information regarding the fundamental psychological processes of mental disorders as patients could contribute knowledge that rests on having gone through that experience (Flanagan, 2010, p.298-299). This presumes that the quality of the knowledge is

vastly different from “expert knowledge” by diagnosticians. Using a thought experiment by Dings & Tekin, I will further argue for the additional value of including patient knowledge in the diagnostic criteria because patient knowledge's quality differs from expert knowledge. Dings & Tekin introduce the hypothetical scenario wherein Sarah is deemed an expert on depression.

“Sarah is often called an expert on depression: after all, she graduated from medical school and has a PhD in neuroscience. She knows all theories of depression, whether biological, psychological, or social. Thus, she knows all there is to know about depression – its genetic and neurological underpinnings, its developmental origins, its relation to stress, the role of particular neurotransmitters, and so on. Sarah has run many clinical studies; she has conducted numerous in-depth interviews with patients (and their families and friends) and has years of clinical experience treating patients diagnosed with depression. Yet at some point, she, herself, becomes depressed. Does Sarah learn something new about depression after becoming depressed herself?” (Dings & Teking, 2022, p.1-2)

Dings & Tekin suggest that Sarah does learn something new by gaining the experience and symptoms of living with depression. This knowledge is distinctive in that only by going through the experience of suffering from depression herself does she gain that knowledge (Dings & Teking, 2022, p.2). From this thought experiment, it follows that becoming a patient thus changes the quality of the knowledge, and patient-specific knowledge is gained.

The current formulation of diagnostic criteria has been based on expert knowledge and observable behavior. Firstly, the current diagnostic criteria formulations focus on observable behavior. The focus lies on behavioral patterns that the patient portrays, which the outside world can observe. To a lesser extent, information on how the patient perceives the outside world is included. Notably, only some criteria are formulated using first-person perspectives: how patients regard themselves, the world, or their mental disorder. For example, regarding borderline personality disorder, only two out of nine diagnostic criteria stated in the DSM are formulated about feelings and identity (APA, 2022). This lack of first-person perspective in the diagnostic

criteria is even worse in neurodevelopmental disorders, such as autism and ADHD, wherein first-person perspectives are zero (APA, 2022).

Secondly, the absence of first-person perspectives in the diagnostic criteria implies that only expert knowledge has been used to formulate the diagnostic criteria. From this, we can conclude that there is a distinct type of patient-specific knowledge that has thus far not been included in the formulation of the diagnostic criteria. Due to the exclusion of this patient-specific knowledge, it follows that the diagnostic criteria are incomplete and therefore lead to harm.

As discussed priorly in section 2.3, the hearer would not be able to imagine a patient's experience because it is so unique that words cannot explain it to someone who has not had that same experience. Patient knowledge is therefore crucial to our understanding of mental disorders and the conceptualization of pathological behavior. This information cannot be derived from only observation by third persons.

4.4 Forms of patient knowledge

Having identified that patient knowledge has value, I will further distinguish various forms of patient knowledge. Borkman (1976) was the first to introduce the term “experiential knowledge”. Various scientific literature has been written about a threefold distinction in patient knowledge: an experience is first transformed into experiential knowledge, which, in turn, is transformed into experiential expertise. It has been argued that there is a distinction between “having an experience”, that progresses into, ultimately, experiential expertise (Dings & Tekin, 2022, p.5-6). When applying this to psychiatry, there seems to be an analogy between “new patients” and “having an experience”. New patients experience symptoms and are starting the diagnostic process. However, they lack knowledge and vocabulary to accurately express their symptoms. Contrarily, “experiential knowledge” in psychiatry is represented by the “expert-by-experience”, or “peer workers”. They are individuals, primarily ex-patients, who have lived with their diagnosis, and symptoms and recovered from their mental disorder. They provide patients with peer understanding and hope that they can “get better” (Dings & Tekin, 2022, p.5-6). There is increasing attention to the professionalization of this role in psychiatry. While their exact contribution and role in mental health care remain contested, their added value to psychiatry is

not. Their opinions are taken seriously and play a role in changing the psychiatric field (Dings & Tekin, 2022).

Psychiatry seems to favor the knowledge of “expert patients” above the knowledge provided by new patients. This is understandable, as some might say that new patients have fewer resources to render themselves intelligible. As we have already discussed in section 2.3, new patients suffer from a lack of hermeneutical resources and might struggle to articulate their experiences. This is a fair point to consider. However, it also elucidates how new patients might not be asked to contribute knowledge due to being rendered intelligible. And only when they become “experts-by-experienced” is their knowledge and opinion considered. While the added value of “expert patients” is indisputable, I disagree with the imbalance in the value attributed to the knowledge provided by “expert patients” and “new patients”.

I believe that initial patient knowledge of first-person experiences during the diagnostic process is crucial to better understanding a patient's initial feelings, hermeneutical resources, and the vocabulary they use to “get across” their experiences. If we do not ask “new patients” to contribute their knowledge, then we may risk never understanding how “new patients” articulate their feelings. This knowledge, that every patient has at the start of their diagnostic process, is then never included in the diagnostic criteria. It follows that these diagnostic criteria may never include patient knowledge by “new patients”, exactly the type of knowledge that diagnoses are based on. The diagnostic process aids in the diagnosis of “new patients”, thus it seems crucial that their knowledge ought to additionally be included.

Because the diagnostic process entails a phase wherein “new patients” lack hermeneutical resources to make sense of their experiences, I believe their input is needed to formulate better diagnostic criteria. We have already discussed how overcoming hermeneutical injustice and thus creating hermeneutical resources during the diagnostic process is challenging. An alternative solution then follows. I have discussed in chapter 3 that hermeneutical justice is achieved when individual hearers and institutions value varying ways of articulating and vocalizing experiences by speakers. This can also be applied as a solution when formulating diagnostic criteria.

We need to understand better how patients who lack vocabulary express their symptoms. Expert patients have ample experience, and they have, through therapy, learned the correct terms to describe better what they are feeling. While their knowledge contribution will be valuable, I believe there is a risk of losing patient knowledge when ascribing their knowledge as more valuable than knowledge of “new patients”. It is precisely knowledge of “new patients” that may describe a patient's initial feelings and thoughts when they initially partake in the diagnostic process. Those are the feelings and knowledge diagnoses are formed on. Knowledge by “new patients” is thus crucial in order to accurately make diagnoses. Regarding the diagnostic process specifically, I argue that the knowledge of all patients ought to be attributed a similar value. I conclude that one form of knowledge is not better than the other. Both are needed to improve the diagnostic criteria to represent a patient's symptoms and mental disorder accurately. As a result, epistemic injustice is combatted.

An important remark is that I do not argue for diagnostic criteria to solely be formulated using patient knowledge, nor for expert knowledge to be disregarded. I believe patient knowledge is needed in addition to expert knowledge, and that their accumulated knowledge may attain the most accurate representation of a patient's mental disorder.

4.5 Solutions to combating epistemic injustice in the diagnostic criteria

Having identified epistemic injustice in the current formulation of the diagnostic criteria and established that patient knowledge can make valuable contributions, I will propose a practical way to include more patient knowledge in the following section.

Bueter suggests that patient input should take place on two levels: the accuracy of the diagnostic criteria and the threshold of these criteria. She suggests using first-person accounts as a corrective means against the DSM criteria's value-ladenness, inaccuracy, and incompleteness (Bueter, 2019, p.1069). Her suggestion also achieves testimonial justice: the patient would not be wronged in their capacity as a knower because their knowledge is now included in the criteria. Earlier in this thesis, I also argued for the inclusion of patient knowledge, and we are making similar points. Bueter does not provide practical examples of acquiring the first-person

perspectives of patient knowledge. However, a suggestion could be to acquire self-reported symptoms in patients with a mental disorder.

An important remark about the adaptation of the diagnostic criteria is that its success depends on epistemic injustice being solved in the first and second component of the diagnostic process. While adapting the diagnostic criteria combats epistemic injustice in theory, it may fall short of effectively combating it in practice if it is not addressed in the other two components: patient testimony and observation and conclusion of the diagnostician. Even if we were to modify the diagnostic criteria by including patient knowledge, it is difficult to imagine how it would prevent epistemic injustice if a diagnostician were still to ascribe deflated credibility to their patient's testimony. Additionally, if patients were to engage in self-silencing behavior persistently, then modification of the criteria would also not help, since a correct assessment of a patient's symptoms depends on their sharing of them. The same could be argued in the situation that patients had no power of decision. The solutions provided in chapters 2 and 3 address epistemic injustice in the first two components, thus, are crucial to combat epistemic injustice during the diagnostic process. I believe that if patients are not empowered to speak up and are not attributed more power of decision during the diagnostic process, then epistemic injustice during the diagnostic process will persist. Criteria modification with patient knowledge is desirable and helpful in formulating better and more accurate criteria. However, if the setting during the diagnostic process is designed in a way that structurally disadvantages the patient, then epistemic injustice will never go away. For these reasons, the diagnostic criteria can only be criticized or approached by considering the entire scope of the diagnostic process and the interpersonal relationships that originate there. The criteria must be seen within the context of the diagnostic process as they influence each other and thus cannot be seen separately.

However, two remarks on including patient knowledge to modify diagnostic criteria remain.

4.6 Limitations of including patient knowledge as a corrective means

Firstly, the inclusion of patient knowledge into the specific criteria does nothing to adapt the framework in which these criteria exist. The revision process is opened when the entire framework on how we perceive mental illnesses has already been designed and applied in

practice for decades. It regards a framework issue and how we view psychiatry and mental disorders. The framework has been designed by experts, and how these experts have conceptualized psychiatry and mental disorders. They have decided to distinguish normal from pathological behavior over the years. This distinction seems fair, as they are experts, and this way of expert design has been implemented in all fields of life.

However, by excluding patient knowledge and perspective from the framework debate, we now have a mainly theoretically designed framework. This framework excludes the opinion and perspectives on the conceptualization of mental disorders of those who live with them. Summarizing this paragraph, the only feedback that takes place during revision processes is the limited feedback on an existing framework initially thought of and designed using only expert knowledge and third-person observations.

A second limitation of including patient knowledge to modify diagnostic criteria is that it proves insufficient in considering intercultural differences in perceived and expressed symptoms and behavior in mental disorders. It has been argued how the inclusion of more cultural nuances and context of criteria is needed. Bredström (2019) explains how despite the APA's efforts to adopt culturally inclusive criteria in its fifth edition, their ethnocentric approach is still identified in various criteria sets (Bredström, 2019, p.357). Bredström explains by using an example how the DSM criteria sets seem to ascribe universal value to specific criteria while choosing to exclude a different criterion as universal and labeling it as a culturally specific expression instead (Bredström, 2019, p.357).

For example, in the case of Panic Disorder, the APA identifies shortness of breath as a universal criterion while identifying uncontrollable crying as a culturally specific expression. She further writes: "*How* culture informs the DSM-disorders is nevertheless still left untold. Thus, despite the attempts, the core problem remains: the DSM-disorders are not subjected to the cultural critique, and cultural aspects are still presented as relevant only for "other cultures." (Bredström, 2019, p.357).

While it initially seems that including first-person criteria as an additional criteria set may serve as a corrective against these cultural differences, I am afraid there will never be one diagnostic tool that will accurately represent symptoms and behaviors of mental disorders across all societies and cultures. Suppose symptoms and behaviors are observed and adopted as diagnostic criteria, but the expressed symptoms and behaviors vary interculturally. Then, how can one universal truth be thought of without ascribing higher or lower value to a particular expression of symptoms and behaviors? I fear that the inclusion of minority groups, culturally different groups, or marginalized groups within society will be structurally undermined by being misdiagnosed due to culturally insensitive and unfairly designed diagnostic criteria. Therefore, it should be considered whether the option exists to formulate culturally sensitive diagnostic criteria. If this is impossible, then it should be considered whether the diagnostic criteria may differ per culture or society.

4.7 Objections to the inclusion of first-person criteria in the diagnostic tool

A possible objection to the inclusion of first-person criteria in the diagnostic tool could be that patients might not always be able to distinguish their mental disorders from personality traits. Suppose we were to ask patients to describe their inner feelings associated with their mental disorder and adopt those into the diagnostic criteria. We would risk individual patients suggesting their inner feelings and parts of their identity as segments or portions of a mental disorder. If patients cannot distinguish between inner feelings and their mental disorders, and we would adopt those into the diagnostic criteria, then the lines between mental disorders and personality traits or identity would become blurred. The risk of my proposal is that certain standard parts of personality or identity would be confused with symptoms of mental disorders and that standard parts of identity or personality would be adopted as diagnostic criteria of a mental disorder. The harm is in the possibility that people without a mental disorder would identify with the criteria of patients with a mental disorder, ultimately leading to the overdiagnosis of people without a mental disorder. This poses two problems.

Firstly, distinguishing between normal behavior and dysfunctional behavior would become more complex. It would open the debate for identity versus mental disorder. The current criteria for a mental disorder diagnosis hold dysfunction as a categorical prerequisite. This means that

whichever criteria a patient meets, their dysfunction in society is required. Without dysfunction, it is nearly impossible to diagnose a patient with a mental disorder. The same rule could be applied in this debate. To prevent the line between normal and dysfunctional behavior from becoming too blurred, the basic criterion for dysfunction must be kept or we would risk an individual without a mental disorder getting diagnosed with any disorder as long as they identify sufficiently with it.

This brings us to our next problem: who gets to decide who has a mental disorder and who does not? A possible way to prevent this is that psychiatrists still need to give a seal of approval before an individual receives a diagnosis.

Another problem that arises, however, is the extent to which somebody dysfunctions in society are determined by the norms and culture of that specific society. This may unfairly disadvantage non-natives, people with differing heritage, refugees, etc. This cultural matter being raised again only underlines the complexity of addressing the cultural debate in psychiatry effectively.

4.8 Recap

In summary, mentally ill patients are being withheld the opportunity to contribute patient knowledge due to the lack of rational knowledge that they are believed to be able to contribute about their symptoms. This is problematic because the very act of withholding them from the debate, pre-emptive testimonial injustice, rests on epistemic injustice. Secondly, patients are misdiagnosed, which we could decrease by including patient knowledge on several aspects of these criteria.

I have argued for the moral impermissibility of purely third-person accounts in a diagnostic tool such as the DSM because several accounts of epistemic injustice occur. In conclusion, adopting first-person accounts into the diagnostic criteria would help alleviate (at least the majority of) epistemic injustices in the diagnostic process. I have argued for the reformulation of diagnostic criteria wherein all patient-knowledge in the form of first-person accounts are included.

Conclusion

Throughout this thesis, I have critically examined the conceptualizations of testimonial and hermeneutical injustice when applied to the diagnostic process in psychiatry. I have made a threefold distinction in the diagnostic process by dividing it into three components; i) patient testimony, ii) observation and conclusion of the diagnostician, and iii) diagnostic criteria.

Regarding patient testimony, I have identified the presence of self-silencing behavior: testimonial smothering, as conceptualized by Dotson. As a corrective, I explored Fricker's conceptualization of testimonial justice and concluded it is applicable only partly: when correcting for unintentional epistemic injustice leading patients to self-silence.

As a practical solution, I proposed increasing empowering tactics in the consultation room to discourage self-silencing behavior, with the aim of encouraging the patient to speak up in such a way that they contribute patient knowledge, and their testimony accurately represents their symptoms. Regarding the observation and conclusion of the diagnostician, I have identified testimonial injustice in the form of testimonial quieting. In addition, hermeneutical injustice was identified as a result of hermeneutical impoverishment during patient testimony. Diagnosticians, as a result, misunderstand patients and inaccurately assess their symptoms. Patient knowledge is not correctly included, leading to epistemic injustice and harm. As a solution, I discussed Fricker's testimonial and hermeneutical justice conceptualization. Testimonial justice provides no answer because it does not consider the implicit nature of biases and thus does not consider that these biases are exempt from rational consideration and reflection, the exact requirement on which Fricker's notion rests. Hermeneutical justice as a corrective means against hermeneutical injustice may prove helpful, however shift additional responsibility towards the diagnostician. I explored the power dynamics between patient and diagnostician and, as a solution, proposed attributing patients increased power of decision. I argued that it might serve as corrective means to diagnosticians' inaccurate conclusions by attributing the patient more power of decision during every step of the diagnostic process.

Regarding the diagnostic criteria, I have argued that their current formulation leads to epistemic injustice by using Bueter's identification of *pre-emptive* testimonial injustice. The exclusion of patient knowledge from the diagnostic criteria is epistemically unjust. Its effects are equally harmful due to their focus on observable behavior and being designed by expert knowledge. I

have argued that due to the resulting epistemic injustice and harm, diagnostic criteria formulated using only third-person perspectives and observable behavior are not morally justified. I conclude that these criteria become more accurate and epistemically just by using patient knowledge to formulate an additional set of diagnostic criteria. Their use, therefore, becomes morally justified.

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