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Research article

Experiences of Epistemic Injustice in the Spanish Psychiatric System: A Qualitative Analysis from the Perspective of Mental Health Activists

Experiencias de injusticia epistémica en el sistema psiquiátrico español: un análisis cualitativo desde la perspectiva de activistas de salud mental

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Abstract
Introduction: This study explores the critical discourse of patients and activists regarding their personal experiences within the Spanish Psychiatric System, highlighting the challenges they face when interacting with mental health professionals and resources. **Methodology:** A descriptive qualitative design was employed. From 2021 to 2022, five focus groups (n=32) were conducted with individuals diagnosed with mental health issues. The participants' varied interactions within the psychiatric system provided insights into their diverse experiences and

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perspectives. **Results:** Participants frequently reported not feeling adequately listened to by mental health professionals, lacking involvement in decisions concerning their treatment, and experiencing barriers to full societal participation due to their psychiatric diagnoses. **Discussions:** Through Fricker's concept of epistemic injustice, examples of testimonial and hermeneutic injustice were identified, highlighting how patients feel their voices and experiences are undervalued, impacting both their care and their ability to engage as citizens. **Conclusions**: The study emphasizes the urgent need to involve patients in decisions regarding their treatment, based on their own experiences, and to improve their societal inclusion, ensuring that their perspectives are heard and respected.

Keywords: mental health; epistemic injustice; societal participation; psychiatry; qualitative research; testimonial injustice; hermeneutical injustice; patient involvement.

Resumen

Introducción: Este estudio examina el discurso crítico de pacientes y activistas en torno a sus experiencias personales dentro del Sistema Psiquiátrico Español, poniendo de relieve las dificultades que enfrentan en su interacción con los profesionales y recursos de salud mental. **Metodología:** Se empleó un diseño cualitativo descriptivo. Entre 2021 y 2022, se llevaron a cabo cinco grupos focales (n=32) con personas diagnosticadas con problemas de salud mental. Los participantes han interactuado con diversos recursos y profesionales del sistema. **Resultados:** Los participantes informaron no sentirse adecuadamente escuchados por los profesionales de salud mental, así como una falta de participación en las decisiones sobre su tratamiento. También señalaron que un diagnóstico psiquiátrico les genera barreras para integrarse plenamente en la sociedad. **Discusión:** Utilizando el concepto de injusticia epistémica de Fricker, se identificaron casos de injusticia testimonial y hermenéutica, donde los pacientes sienten que sus voces y experiencias no son valoradas. Esto afecta tanto su tratamiento como su capacidad para participar como ciudadanos. **Conclusiones:** El estudio subraya la necesidad urgente de involucrar a los pacientes en la toma de decisiones sobre su cuidado, basándose en sus propias experiencias, y de promover su inclusión activa en la sociedad.

Palabras clave: salud mental; injusticia epistémica; participación social; psiquiatría; investigación cualitativa; Injusticia testimonial; injusticia hermenéutica; participación de los pacientes.

1. Introduction

The field of madness has always been a source of controversy and the subject of numerous debates. A historical review of the literature can aid in comprehending the complexity of this phenomenon and the varied treatment it has undergone over time. Presently, psychiatry, and therefore medical knowledge, bears responsability for its management. Thus, numerous criticisms have been directed at psychiatry, particularly towards large psychiatric institutions. Concepts such as *stigma*, *sanism*, or *total institution* have been developed, achieving considerable success in terms of the reform and humanization of psychiatric institutions (Foucault, 2006; Pietikäinen, 2015; Read et al., 2004; Scull, 2018).

However, contemporary psychiatry remains a subject of ongoing debates and criticisms. Specifically, some argue that it has become excessively fixated on pharmacological aspects, neglecting the therapeutic and human connection. It has also been emphasized that psychiatry is a profession rife with value judgments, a characteristic that can be problematic. Additionally, it has been pointed out that it is a profession that can be highly intrusive, as it may involve coercive measures and even deprivation of liberty.

All these issues can be understood as indicative of an identity crisis within psychiatry itself (Gardner & Kleinman, 2019).

Recently, a new concept has been incorporated into the vocabulary of academics and activists in the field of psychiatry: *epistemic injustice*. This is a concept that has been quickly assimilated and has become part of the set of existing critical concepts and epistemologies (I. J. Kidd et al., 2017, 2022; McKinnon, 2016; Medina, 2012; Sherman & Goguen, 2019).

Epistemic injustice is a term coined by the philosopher Miranda Fricker (Fricker, 2007, 2017), referring to a type of injustice where individuals are harmed as knowers or knowledge generators, as epistemic agents. Fricker distinguishes between two types of *epistemic injustice*: *testimonial injustice* and *hermeneutical injustice*. *Testimonial injustice* occurs when a person's credibility is diminished based on prejudices and stereotypes, while *hermeneutical injustice* refers to a lack of access to certain interpretations or knowledge due to structural inequalities in society. Other authors have delved deeper and further developed these concepts (McKinnon, 2016).

Fricker starts from the concept of an unfairly distributed *credibility economy*. Epistemic injustice occurs when a speaker is given either too much or too little credibility. In this context, *testimonial injustice* occurs when a person experiences a deficit in credibility based on prejudice (Fricker, 2007, 2017). Fricker provides two examples linked to racial prejudices in one case and gender prejudices in another. In the same vein, Medina (Medina, 2011, 2012) criticizes the notion, arguing that credibility is not a distributable commodity (in the logic of an economy) but should be understood as an interactive matter. Furthermore, he suggests not overlooking the harms caused by excesses of credibility, an aspect that Fricker only marginally addresses.

Taking it a step further, other concepts derived from *testimonial injustice* include *testimonial quieting* and *testimonial smothering* (Dotson, 2011). *Testimonial quieting* occurs when an audience, due to an identity prejudice, does not regard the speaker as a knower. In other words, not only does the speaker suffer a credibility deficit, but their discourse is entirely ignored. It is as if they had not spoken at all. *Testimonial smothering* happens when the speaker knows or senses that the audience is hostile, leading them to decide not to speak.

Hermeneutical injustice occurs when the distribution of hermeneutical resources is not equal (knowledge, concepts, credibility) (Fricker, 2007, 2017). In other words, when a socially disadvantaged group is intentionally or unintentionally obstructed from accessing knowledge or from communicating knowledge to those in more privileged positions due to a gap in hermeneutical resources, *hermeneutical marginalization* takes place. Fricker's example is that of sexual harassment in the workplace. Before the rise of feminism, women were unable to understand their own experiences and the discomfort they felt with male behaviors that are now recognized as harassment.

Following this line of thought, *hermeneutical injustice* results in two kinds of unknowing (Mason, 2011). Unknowing on the part of the oppressed in recognizing themselves as oppressed, and unknowing on the part of the dominant social groups who are unaware of the oppression faced by marginalized groups.

There can also be *willful hermeneutical unknowing* (Pohlhaus, 2012) when socially dominant groups refuse to acknowledge epistemic tools developed from the experiences of those situated at the margins. For example, the concept of a *rape culture* may be actively denied by many men who, as a result, do not see or understand how it operates, perpetuating the oppression of women.

This new conceptual framework aligns well with the critiques and debates present in the psychiatric field today. Recently, a broad number of articles have been published that relate these concepts to delirium (Bortolotti, 2015; Sanati & Kyratsous, 2015), voice hearing (Harris et al., 2022), suicidal attempts (Sullivan, 2019), mental health research (Groot et al., 2022; I. J. Kidd et al., 2022; Okoroji et al., 2023), children and youth with unusual experiences and beliefs (Harcourt, 2021; Houlders et al., 2021), human rights advocacy (Daya et al., 2020; Newbigging & Ridley, 2018), the incorporation of Shared Decision-Making processes (Carrotte et al., 2021; Grim et al., 2019; Zisman-Ilani et al., 2021), overmedicalization (Gagné-Julien, 2021) or biological reduccionism (Degerman, 2023), as well as the development of diagnostic classifications (Bueter, 2019), among other issues (Carel & Kidd, 2014; Drożdżowicz, 2021; Hultman & Hultman, 2023; Ritunnano, 2022; Scrutton, 2017; Tate, 2019).

Despite this, these investigations have not been immune to criticism, primarily based on the argument that the concept of epistemic injustice adds nothing new to clinical ethics (Kious et al., 2023). However, for instance, this criticism is focused on the relationship between the psychiatrist and the patient, overlooking the structural hermeneutical injustice. Furthermore, the fact that critiques made under the umbrella of epistemic injustice are addressed in ethical codes does not necessarily imply compliance in everyday practice.

It is important to note that epistemic injustice is not the sole factor contributing to discrimination in mental health. Economic, social, and cultural inequalities can also play a significant role. However, addressing epistemic injustice is crucial to ensure that all individuals, regardless of their socioeconomic status or mental health, have access to accurate and useful information and resources for their psychological well-being.

This article examines the critical discourse of patients and activists within the Spanish Psychiatric System, applying Fricker's concept of epistemic injustice to illuminate issues such as inadequate communication, limited involvement in treatment decisions, and challenges in societal participation.

2. Methodology

2.1. Design

A qualitative research approach was used in this study. The descriptive and exploratory scope of this article allows for an understanding of the subjectivities of individuals and their perspectives. It is based on an approach rooted in *standpoint theory* (Harding, 1991; Harding, 2004), which aligns with the conceptual framework from which this article originates: *epistemic injustice*.

Thus, the premise is to begin thinking from marginalized lives, assuming they have an epistemically privileged standpoint. In this regard, the concept of *strong objectivity* has been employed to incorporate the voices of individuals in socially marginalized positions that are traditionally silenced (Harding, 1992, 1995, 2013).

2.2. Participants

The participants were 17 men and 15 women with ages ranging from 25 to 62 years. All of them (1) have been patients in the Spanish psychiatric system and (2) are members of collectives, groups, or patient associations.

This is a non-probabilistic convenience sampling. The study reached out through email, social media, or personal contacts with most associations, collectives, and mutual aid groups in Spain, which then disseminated the study among their members. Ultimately, 32 individuals participated in the study, leading to a theoretical saturation point.

The sociodemographic data of each participant is presented below [See Table 1].

Table 1

Sociodemographic characteristics of participants

	Age	Gender	Marital Status	Education level	Occupation	Income level	Living arrangement
G1H49	49	Male	Single	University degree (not finished)	Pensioner	553€	With mother
G1H47	57	Male	Single	University degree (not finished)	Pensioner	950€	Shared Flat
G1H50	50	Male	Single	Compulsory Education	Pensioner	900€	Alone
G1M39	39	Female	Single	University degree	Pensioner	Not specified	Alone
G1M49	49	Female	Separated	Compulsory Education	Pensioner	800€	With parents and sons
G1M62	62	Female	Married	University degree	Pensioner	400€	With partner
G2H52	52	Male	Divorced	University degree	Pensioner	1000€	With partner
G2H44	44	Male	Divorced	University degree	Pensioner	1080€	Alone
G2M54	54	Female	Widow	Compulsory Education	Pensioner	800€	With daughter
G2M29	29	Female	Couple relation	University degree	Worker	1000€	With partner
G2M44	44	Female	Married	Compulsory Education	Pensioner	Not specified	With partner and 3 sons
G2M41	41	Female	Single	University degree	Student	Not specified	With parents
G2M34	34	Female	Married	Compulsory Education	Pensioner	650€	With partner and daughter
G2H48	48	Male	Single	Compulsory Education	Pensioner	Not specified	With parents
G2H27	27	Male	Single	Compulsory Education	Worker	1000€	With brother
G2M39	39	Female	Single	Compulsory Education	Pensioner	850€	Alone
G3H43	43	Male	Single	Vocational Training (FP)	Worker	500€	Shared Flat
G3H24	24	Male	Single	University degree (not finished)	Student	No Income	Shared Flat
G3M47	47	Female	Married	University degree	Pensioner	2700€	With partner
G3H45	45	Male	Single	University degree	Pensioner	550€	Alone
G3H25	25	Male	Single	University degree	Worker and student	1000€	Shared Flat
G4M37	37	Female	Single	Vocational Training (FP)	Pensioner and worker	1000€	With partner

G4H43	43	Male	Single	University degree	Pensioner	850€	With parents
G4M45	45	Female	Single	University degree	Pensioner	Not specified	Alone
G4H58	58	Male	Married	University degree	Pensioner	1000€	With partner
G4M49	49	Female	Single	High school diploma	Worker	700€	Shared apartment
G4H57	57	Male	Divorced	Vocational Training (FP)	Pensioner	2000€	With partner
G5H51	51	Male	Married	University degree	Pensioner	NC	With partner
G5H40	40	Male	Single	Vocational Training (FP)	Pensioner	900€	With partner
G5H55	55	Male	Single	Vocational Training (FP)	Pensioner	1000€	With partner
G5M48	48	Female	Married	High school diploma	Pensioner	2288€	With partner and daughter
G5M43	43	Female	Not specified	University degree	Pensioner	700€	With partner

Source: Developed by authors.

2.3. *Data Collection*

The information was collected online between December 2021 and March 2022. The technique used to gather information was the focus group. The focus groups were conducted by the first author of this article through various tools (Jitsi, Microsoft Teams, or Google Meet), depending on the tool that the group participants were more familiar with. Additionally, before each focus group, a brief questionnaire was administered to collect some sociodemographic data.

The facilitation of the group was based on introducing a provocative topic that did not directly address the subject of this article. In this case, the provocative theme was the concept of participation. The aim was to encourage spontaneous discussion and break away from the typical question-and-answer dynamic between the interviewer and the participants.

However, the moderator must engage in active and careful listening, demonstrating interest in what the participants are saying. Similarly, the moderator can seek clarifications, redirect the discussion when it deviates from the research objectives, and explain the estimated duration and focus group' s structure.

The duration of the focus groups was around two hours. A total of 5 focus groups were conducted. Each participant received informed consent via email and had the possibility to ask questions before the focus group began. The groups were audio-recorded and transcribed for later analysis.

All research was conducted in accordance with The European Code of Conduct for Research Integrity (Dusol, 2023). A robust commitment to ethical standards was consistently upheld throughout the study, with participants being duly informed about the research's objectives. Informed consent was obtained as a mandatory prerequisite for participating in the focus groups. To uphold confidentiality, data were anonymized, and measures were implemented to ensure the privacy and secure storage of information in protected files, limiting access solely to the research team. This ethical framework aligns with the principles guiding qualitative research, particularly in the context of focus groups.

2.4. *Data Analysis*

Any qualitative research involves a circular process, meaning that different stages of the methodological process are revisited iteratively, including literature review, coding, recoding, and the incorporation of theoretical-methodological reflection.

Nevertheless, we will present the methodological process in an ordinal manner to facilitate comprehension for the reader. First, we transcribe and conduct an initial reading of the material, making initial conjectures. Second, aligning with the objective of this article, we code and select verbatim excerpts that illustrate testimonial and hermeneutical injustices.

The analysis was conducted with the support of the qualitative analysis software Atlas.Ti 23. Regarding the presentation of results, we have opted for an interpretative level, engaging in an analytical exercise of synthesis, selection, and interpretation, beyond a continuous presentation of direct quotations. Thus, considering the circular logic of qualitative research, we have decided to present results and discussion in the same section.

3. Results and discussion

In this section, we will proceed to present the results in a narrative form, focusing on the ideas of testimonial injustice and hermeneutical injustice. It's worth mentioning that testimonial injustice and hermeneutical injustice are interconnected, and there are testimonies that could serve to highlight both types of injustice.

3.1. Testimonial injustice

As previously mentioned, testimonial injustice adversely affects individuals in their capacity as knowers. This harm is not trivial, as it implies damaging individuals as members of humanity, since the ability to know and reason is intrinsic to human beings (Fricker, 2007).

In the field of psychiatry, testimonial injustice holds particular significance. The presence of certain psychiatric diagnoses (such as schizophrenia), by definition, implies a deficit in reasoning capacity. Symbolically, the act of diagnosis may therefore degrade individuals in terms of their belonging to citizenship, as human beings.

In addition to this primary harm of testimonial injustice, Fricker identifies a secondary harm (Fricker, 2007). The stereotypes and prejudices arising from this injustice may be shared by the harmed individuals themselves, as well as by those perpetrating the harm, thus reinforcing them. Consequently, there may be practical consequences such as a loss of confidence in one's own capacity as a knower, in one's own intellectual ability. Once again, within the psychiatric field, this presents significant ethical issues.

In certain diagnoses, concepts such as treatment adherence or illness awareness entail accepting this premise. That is to say, patients are led to assume that they must question their own belief systems because they are unwell, uncritically accepting the guidelines of healthcare personnel.

As a result, a scenario arises in which, firstly, there is an excess of credibility within the medical profession, and secondly, patients experience a deficit of credibility due to their psychiatric condition.

In the focus groups, the difficulties faced by individuals receiving care in the Spanish psychiatric system in being heard or considered in decisions about their own treatments are repeatedly mentioned.

In the following verbatim, one of the participants expresses it as follows:
"G5M42: Of course, normally you trust your doctor. Your psychiatrist, and if... if he advises you to take so many pills a day... You say, well, then it must be because... what he recommends is what I need... G5M48: No, and you take them convinced..." (G5M42; G5M48)

These harms can have serious epistemic and practical consequences, prompting reflections on the principle of nonmaleficence in bioethics. Although this principle is typically applied with reference to physical harms, there is nothing to suggest that it should be limited to such. In other words, the principle of *nonmaleficence* should also address mental or moral harms (Della Croce, 2023). There are reasons to believe that diagnoses have a performative nature.

As Davidson (Davidson, 2004) argues, psychotic diagnoses often involve tautological reasoning: the psychotic experience undermines the credibility of such experiences, and, in turn, this delegitimization allows for the inference of a psychotic disorder.

Carel and Kidd (Carel & Kidd, 2014; H. C. Kidd Ian James, 2017; I. J. Kidd & Carel, 2017) discuss epistemic injustices within the realm of healthcare. While most individuals with illnesses can articulate their own experiences, they are often 1) deemed inappropriate for public discussion and 2) lack significance in decision-making processes. In the field of psychiatry, these challenges are heightened (Crichton et al., 2017; I. J. Kidd et al., 2022; Scrutton, 2017).

Another quote that delves into the same idea is as follows:

"Many times, I notice that the psychiatrist talks to me from up here, with such a high level of wisdom and sometimes... it comes across as so arrogant that it leaves me down here... that everything he tells me. I have to do or everything he says... is something that has to be taken as gospel... That's something that hurts me... because when I mention a fear to him, or when I mention some symptom... Well, maybe... after telling him, I think: should I have told him or should I not have told him? Then that relationship or bond of so much security or so much participation is not created... When I go to the psychiatrist, I say... How are you? Good, and about the other? Good, and the voices? No, none... And maybe I do have voices..." (G2H27).

The epistemically privileged position of the psychiatrist nullifies the epistemic agency of the affected person. In other words, the one deemed capable of producing and applying knowledge is the psychiatrist, who generates expert knowledge. On the contrary, the diagnosed person lacks credibility and feels unheard, to the extent that they doubt what should or should not be said and, at times, choose to conceal information about themselves.

When considering the increased, multiplied or even exponential credibility accorded to professionals, particularly mental health professionals, it is clear that this credibility is often derived from their position rather than from hard data or demonstrable outcomes. A cardiologist's credibility is based on tangible metrics and measurable outcomes, whereas a psychiatrist's credibility is often amplified by the authority inherent in his or her role.

This phenomenon, which might be termed "epistemic omnipotence", underscores the dynamic in which the psychiatrist's perceived infallibility is closely tied to his or her status, rather than to demonstrable clinical efficacy or empirical evidence.

Here we can glimpse one of the possible consequences of testimonial injustice, which will be further explored throughout the article. It can be observed that a distrust towards healthcare assistance is generated. In the cited instance, only symptoms in relation to medication matter, regardless of the individual's relationship (positive or negative) with their own symptoms or medication, and, of course, their preferences. This consequence, along with over/under-medication or increased stress, was identified in the case of fibromyalgia. In this instance, prejudices against women and pathocentric biases were observed. (Della Croce, 2023).

Furthermore, it can be observed that the participant sometimes chooses to lie to the psychiatrist, based on the perception of the psychiatrist as a hostile audience and the belief that telling the truth won't benefit them. This could be identified as an example of *testimonial smothering* (Dotson, 2011).

Another participant expresses it as follow:

"We have to somehow find a way for that... to be looked at in a more human way, for us to be understood, for us to be heard" (G5M43).

In this quote, it is evident that there is a complaint indicating that they are not seen as human beings. This sentiment is repeated several times in the focus groups. This could imply that going through psychiatric services may degrade one's status as a person or as a citizen with rights and responsibilities.

One consequence of biological reductionism in psychiatry is to produce individuals who are ontologically different from others (Hall, 2017; Haslanger, 2017; Lakeman, 2010), concealing other alternative social explanations for people's suffering. In other words, having a diagnosis can lead to being treated differently because there is something deemed inherently different.

Radical naturalistic explanations frequently entail, especially within the field of psychiatry, the acceptance that communication may be constrained by an illness that impacts cognitive faculties, including thinking, knowledge acquisition, and reasoning abilities. It could be contended that testimonial injustice finds justification through the lens of naturalistic scientific understanding: individuals are perceived as diminished in their capacity as knowers due to identified deficits or imbalances in brain function. This has implications for treatment, primarily medical, and for overshadowing alternative interpretations (resulting in a "pathocentric hermeneutical injustice", addressed in the following section). In conclusion, it becomes plausible to consider that certain theoretical conceptions of health may be epistemically unjust (I. J. Kidd & Carel, 2018).

This *natural difference* could explain, at least in part, some barriers to participating as citizens in civil society:

"[…] Another thing that held me back from participating is feeling too different... the fear that I'm going to participate and be taken as a person who doesn't know what they're talking about... or a person who has no right to express an opinion" (G2H27).

"[...] We are excluded from it and we are the voiceless ones, those... Those whom no one listens to... A bit like that, right? So, having a diagnosis may limit us in that sense." (G1H47).

In one of the last quotes, it can be observed how feeling "too different" made it difficult for one of the participants to participate, fearing that they won't be listened to because they don't know what they're talking about (*testimonial quieting*); hence, sometimes it's better not to participate at all (*testimonial smothering*) (Dotson, 2011). This could lead to *hermeneutical marginalization*.

Nonparticipation also occurs when patients are not considered in decision-making processes. When patients disagree with clinical assessments and the suggested recommendations or treatments, this resistance is often attributed to the mental illness itself (Coghlan & D'Alfonso, 2021). Thus, epistemic injustice (and *pathocentric hermeneutical injustice*) justify the possibility of disregarding patients' preferences and implementing coercive measures (Daley et al., 2019; Gustafsson et al., 2014; Nyttingnes et al., 2016).

In other words, if the testimony of the individuals being treated is not deemed credible or relevant, the physician is the one who must take appropriate measures to treat the individuals, even against their own will.

Considering this, it makes sense to advocate for participatory research approaches in bioethics, incorporating multiple voices and perspectives (not only those of healthcare professionals), which has been shown to be relevant in reducing coercion in psychiatry (Abma et al., 2017).

This phenomenon is further elucidated in the focus groups, where all participants critique what they describe as psychiatric violence: coercive interventions such as mechanical and chemical restraint, involuntary admissions, and overmedication, among others. They contend that these coercive measures are imposed on them due to their perceived inequality as human beings with rights. Consequently, they assert that their viewpoints are neither acknowledged nor integrated into the treatments they receive.

"We also end up tied many times because we are not seen as people... The idea that the mad don't suffer... And we remain so unaffected... and sometimes it even seems amusing to poke fun at a mad person" (G2M54).

In the field of health, particularly with the biotechnological revolution, there is a decreasing reliance on patients as informants, with greater attention given to other objective findings such as physical tests, blood analysis, imaging techniques, and so forth. This, in itself, is problematic as it may overlook the psychological, social, cultural, and existential dimensions of the illness experience, leading to the objectification of the patient (Ramsey et al., 2002).

However, in psychiatry, this poses a profound ethical issue. Firstly, due to the type of suffering or distress being addressed, which is inherently subjective. Secondly, because there are scarcely reliable and objective physical tests for diagnosis. And thirdly, because the expressions and behaviors of the patient are often treated as objective findings.

In other words, they are regarded as useful physical symptoms for diagnosis rather than genuine expressions of the individual. The objectification of patients is thus much more pronounced (Sakakibara, 2023). Any type of physical or verbal expression can be interpreted as symptomatic of a mental disorder. This phenomenon could be termed *Epistemic Diagnostic Bias*.

This concept focuses on the inherent bias in knowledge and interpretation that arises from a preconceived diagnostic label. It highlights the pervasive issue of interpreting all behaviors through the prism of a pre-existing diagnosis, thereby reinforcing and perpetuating existing prejudices. This bias not only undermines the individual's credibility but also limits the scope for alternative explanations and more accurate understandings of their actions and statements.

By framing every behavior within the confines of the initial diagnosis, epistemic diagnostic bias creates a self-fulfilling prophecy that entraps individuals in a cycle of misunderstood and misrepresented mental health conditions. Moreover, the biotechnological revolution in the field of mental health is just around the corner, bringing forth new ethical issues of epistemic injustice, among others. (Coghlan & D'Alfonso, 2021).

An example of the consequences of testimonial injustice is provided by Saks in her book (Saks, 2007). When Saks went to the emergency room for an unusual headache, the doctor, upon seeing her diagnosis of schizophrenia, interpreted it merely as a symptom of a psychotic episode, and thus sent her home without conducting any medical examination or tests. Such experiences have been conceptualized under the term "diagnostic overshadowing" (Bueter, 2023).

In Spain, a case of testimonial injustice and diagnostic overshadowing of a much more extreme nature occurred. From April 18 to 20, 2017, Andreas visited the Emergency Department of the Central University Hospital of Asturias (HUCA) three times. Despite being initially diagnosed with tonsillitis, his symptoms worsened, including fever, auditory hallucinations, and significant anxiety.

After medical evaluation and considering his family's psychiatric history, it was concluded that his condition was solely psychiatric in nature, resulting in his admission to the Psychiatric Unit. The following day, Andreas expressed a desire to leave the facility, leading to his involuntary admission and the application of mechanical restraint measures, which continued until his death on April 24.

According to the forensic report, Andreas died from “lymphocytic meningitis + myocarditis,” despite never receiving treatment. This raises questions about attributing his behavioral changes exclusively to a psychological disorder, without conducting a more comprehensive diagnostic evaluation, including consideration of other symptoms such as high fever (Trujillo, 2020).

Some participants in the focus groups pointed out instances of this “diagnostic overshadowing”, albeit in less extreme terms.

“There's one who has... I mean, who has knee problems and doesn't go to public healthcare because she was... when she went for knee problems she ended up admitted to psychiatry”. (G3H25).

However, one of the factors contributing to higher mortality rates among individuals diagnosed with mental health issues may be the lower level of physical healthcare provided to these individuals (Bueter, 2023). On one hand, this is derived from the testimonial injustices highlighted earlier. On the other hand, individuals may not seek healthcare due to their past negative experiences.

Another one of the most common issues that participants in the focus groups perceive as psychiatric violence is overmedicalization. Similar to coercive measures, overmedication can be related to testimonial injustices (Gagné-Julien, 2021), but also to a form of *preventive testimonial injustice* (Bueter, 2019).

Bueter (Bueter, 2019) argues that the exclusion of individuals with psychiatric diagnoses from the work of developing categorical diagnostic systems constitutes a preventive testimonial injustice. In other words, this injustice occurs even before any interaction takes place with individuals or groups susceptible to experiencing the injustice.

To conclude this section, here is a quote that illustrates the consequences that epistemic injustice might be having in the Spanish psychiatric system. As the person has nothing to say, or what they say is considered delusional, it doesn't matter if overmedication nullifies them as an individual:

“I am totally overmedicated... I am a complete zero... It doesn't let me, it doesn't let me be myself, it doesn't let me think, it doesn't let me express myself, it doesn't let... And every admission... that I usually have... they give me a pill, and another pill, and another pill, and another pill... So they don't realize... what I am taking... They just give me one more pill, or two more pills... So, it doesn't let me think, it doesn't let me... I am blocked... All day asleep, all day... [silence]... I am a null person... And that... Well, that's what I wanted to mention…” (G2M39).

3.2. Hermeneutical injustice

As initially proposed, testimonial and hermeneutical injustice are closely related. Additionally, hermeneutical injustice has a much more abstract and philosophical character, focusing on an unequal distribution of hermeneutical resources.

Therefore, to operationalize the concept, we propose understanding hermeneutical resources as those "shared tools of social interpretation". (Fricker, 2007) p. 6.

In this vein, biological reductionism, or *Pathocentric Epistemic Injustice* (I. J. Kidd & Carel, 2019), as we referred to it in the previous section, by obscuring other alternative narratives, is a form of hermeneutical injustice. That is to say, when the biomedical discourse is presented as the only possible narrative, an injustice is being committed by denying individuals the use of other possible "tools for social interpretation".

In the following quote, this idea is expressed as follows:
"I was marked a lot by the biological. Look, it's like, this is the biological, the genetic, family, etc., and such. And I have always been marked with that. Like, I have been all the time with the idea that this is what I've been dealt, this is what I already have... And that has not allowed me to... [...] Personally, it has paralyzed me. It has not let me move forward in my life projects, so to speak..." (G5M43).

The dominance of the biological perspective hinders alternative understandings of people's suffering, which may be linked to forms of social injustice. Medical tests, language, and the very concepts derived from the realm of health are imbued with epistemic privilege (Crichton et al., 2017), a privilege upheld by social and institutional contexts (Scrutton, 2017).

Healthcare systems also exhibit epistemic issues in the power dynamics among different healthcare professionals and non-healthcare professionals, such as social workers. This also results in a hierarchy regarding the hegemonic naturalistic narrative on illness. Furthermore, there may be individual intellectual or moral flaws, but there are also entrenched structures built on stereotypes, assumptions, and practices that may be racist, misogynistic, or, in the case at hand, sanist (I. J. Kidd & Carel, 2021).

Sanism entails prejudiced attitudes towards individuals with psychiatric diagnoses, reinforcing negative stereotypes that dehumanize psychiatrically labeled individuals, similar to how racism degrades people of color or sexism degrades women. Sanism involves treating psychiatrically labeled individuals as inferior, childish, incompetent, or dangerous. It also entails an exclusively pathocentric view of mental illness, deliberately ignoring social causes and structures (Gosselin, 2022; LeBlanc & Kinsella, 2016).

This also entails suppressing individuals' own interpretations of their experiences, concealing explanations rooted in biography, society, or culture. This unquestionably constitutes a form of hermeneutical injustice, as only the biomedical discourse on illness is deemed legitimate.

It is also possible to consider *willful hermeneutical unknowing* on the part of some psychiatry professionals when deliberately ignoring the knowledge generated by individuals subjected to psychiatry. A specific example could be that of Mad Studies (Beresford, 2020; Beresford & Russo, 2021; Gagné-Julien, 2022; Gorman & LeFrançois, 2017; Menzies et al., 2013), as it represents knowledge generated from the experiences of those subjected to psychiatry, with an epistemic framework different from the biomedical one. Sanist prejudice contributes to hermeneutical injustice by marginalizing the knowledge produced by people with lived experiences of mental health issues (LeBlanc & Kinsella, 2016).

By overshadowing other critical discourses with the biomedical discourse on people's suffering, hermeneutic resources are being denied to individuals receiving psychiatric care to be critical of psychiatry and medical knowledge. Similarly, psychiatry may, voluntarily or involuntarily, ignore critical discourses about its own practices, leading to resistance against positive changes in the field of mental health.

Other quotes emphasize how medical knowledge can condition you when deciding to pursue certain studies, activities, or participate in society. Similarly, the loss of rights that often comes with being admitted to a psychiatric hospital is addressed.

“That being a mental health patient conditions you when deciding to pursue certain studies or activities, and... for me, it's something that conditions a lot...” (G2H44).

“Equalizing the rights of people with mental health to the rest of the population... We don't have the same rights... When they admit you, they take everything away...” (G5M48).

Hermeneutical injustice, in this sense, is operationalized by the lack of opportunities for individuals with lived experiences of mental health issues to participate in the generation of interpretative resources to make sense of their own experiences. When lacking alternative interpretative resources, there is a possibility of uncritically accepting either the biomedical discourse or the prejudices and stereotypes that may be socially associated with the diagnosis (LeBlanc & Kinsella, 2016).

For example, the concept of sanism itself allows for the conceptualization, understanding, and interpretation of a set of discriminatory practices. It serves as a hermeneutical resource. Many individuals with lived experiences of mental health issues may be unable to understand and interpret many discriminatory behaviors if they lack access to the hermeneutical framework of sanism, much like many women were unable to interpret the discomfort and distress caused by certain male behaviors in the workplace until the rise of feminism and the recognition of sexual harassment in the workplace (Fricker, 2007).

Many participants in the focus groups do not use medical terms such as mental illness, schizophrenia, or mental disorder precisely because of what they may entail. Instead, they use terms such as madness, suffering, or others that are not directly related to medical language. This can be understood as a form of resistance to hermeneutical injustice (Medina, 2012), creating parallel concepts to medical ones. In other words, generating their own hermeneutical resources, their own “shared tools of social interpretation” (Fricker, 2007).

“Because I hate the word disorder, I hate the word illness. I hate many words to define us." (G1H49)

“We cannot use the word patient. A word that, moreover... It means being something passive. No.” (G3H25)

Another problem pointed out by the participants is related to the discourse of families, which for many years has silenced the discourse of individuals with a psychiatric diagnosis. In addition, criticisms arise, as in the following quote:

"Another form of violence [...] is that your family, those close to you... ignore you in some way or don't count on you... For me, that is important, and especially during hospitalizations, they decide about you and over you without you... [...] they treat us as if we were three years old... Even at the age of thirty-five, the doctor asks who will take responsibility for you... They don't let you go alone in many cases..." (G1M39)

In the same vein, participants criticize the care model that relies on the family, and this criticism can be extrapolated to psychiatric treatment. By treating individuals as if they were children, agency and hermeneutic resources to become aware and lead an autonomous life are also denied.

This relates to the notion of paternalism. The concept of 'paternalistic oppressive othering' (Taylor et al., 2018) is relevant, referring to the set of paternalistic ideologies that construct the superiority of one group in opposition to the supposed infantile inferiority of a less powerful group.

The following quote illustrates this criticism:

"The comfort of the family that does everything for us... that provides us with everything... that sometimes even provides maintenance... The lack of empowerment... The lack of awareness of independence... How my independence can be... What future project I have... Motivation for empowerment..." (G1H47).

Finally, it is worth mentioning that overmedication itself, along with other coercive measures, can act as a barrier for people to participate, communicate, and engage actively in society. Thus, 'psychiatric violence' can produce hermeneutic injustice, either (1) by preventing and hindering individuals from accessing certain knowledge or (2) by obstructing the possibility of communicating knowledge to socially more privileged groups. As mentioned earlier, this leads to a double unknowing: (1) the unknowing of oppressed groups to recognize their own oppression, and (2) the unknowing of socially more privileged groups who may not be aware of the oppression of other groups (Mason, 2011).

In the following quotes, some examples are provided. In the first quote, it is discussed how psychiatry makes it difficult for individuals to participate and be activists. The second quote serves as an example of how medication can de facto hinder this participation:

'There needs to be a significant change in psychiatry for that... Because many people are immersed in psychiatric violence, in medications... and don't have time for activism...' (G3H24).

'I am totally anti-psychiatry, I don't know if there is anyone here, everyone, I am against restraints, electroconvulsive therapy, or whatever you want to call it, and also against... I am taking a lot of medication, and I forget what I am going to talk about.' (G4H43).

The increase in public awareness about racism, sexism, ageism, or homophobia has been closing hermeneutical gaps and has contributed to making these systems socially unacceptable. In the field of mental health, however, there still exists a hermeneutical gap that prevents many injustices and violations occurring within the psychiatric field from being recognized, described, and socially interpreted. Nonetheless, there is greater awareness of human rights in the mental health field, but other types of injustices, more subtle yet equally harmful, remain hidden.

3.3. Limitations

There are limitations regarding the sample used. The results obtained could be specific to this particular group. In other words, they cannot be extrapolated to the entire population with mental health problems, as it represents a very specific profile of individuals who are associated with and engage in mental health activism.

Additionally, the sample used is not sufficiently diverse. For example, there is no representation of any transgender or racialized individuals in the focus groups. In other words, we were not able to conduct structural sampling that included these considered relevant factors.

However, qualitative research focuses on the meaning and understanding of human experiences in specific contexts and does not seek the generalization of results.

4. Conclusions

In conclusion, it is imperative to advance the theoretical development of these issues and to equip ourselves with a comprehensive vocabulary that allows us to accurately name, describe, and analyze the iatrogenic aspects embedded within the epistemic violence of contemporary mental health care systems. By refining our theoretical frameworks and expanding our terminological toolkit, we can better identify and mitigate these negative impacts, thereby fostering more equitable and effective mental health care practices.

In the exploration of the experiences within the Spanish psychiatric system, this study elucidates the pervasive influence of epistemic injustice on patients, constituting a critical discourse. Testimonial injustice, exemplified by the disparate allocation of credibility, lays bare a power dynamic that obstructs transparent communication channels between psychiatrists and patients. The individuals undergoing psychiatric care contend with the poignant perception of being unheard and reduced to diagnostic labels, a circumstance wherein their voices contend against the authoritative discourse emanating from the medical professionals.

The intricate entanglement of testimonial and hermeneutical injustices amplifies the intricacy of the landscape. The disproportionate emphasis on biological reductionism in psychiatric discourse contributes to hermeneutical injustice, circumscribing alternative narratives and constraining social interpretations. The ramifications of this phenomenon reverberate widely, impacting the self-perception, rights, and agency of individuals while concurrently perpetuating societal misconceptions encircling mental health.

The resistance demonstrated by participants, discernible in their deliberate avoidance of medical lexicon and the proactive construction of bespoke hermeneutical frameworks, emerges as an act of empowerment and autonomy set against the backdrop of systemic constraints. The narratives shared by participants illuminate the intersections of epistemic injustice with coercive measures, overmedicalization, and societal perceptions, collectively embodying a multi-faceted challenge for individuals navigating society with psychiatric diagnoses.

It remains imperative to recognize that, while epistemic injustice holds significance, it coexists with other forms of discrimination ingrained in economic, social, and cultural disparities. Nevertheless, the imperative to address epistemic injustice surfaces as a pivotal stride in disassembling barriers to precise information and mental health resources. The research findings underscore the exigency for a paradigmatic shift in psychiatric practices, advocating for an inclusive and collaborative approach that acknowledges the diverse perspectives and agency of individuals within the system.

Amidst the ongoing debates surrounding contemporary psychiatry, the proactive acknowledgment and mitigation of epistemic injustice stand poised to sculpt a more equitable and compassionate terrain within the realm of mental health. This study thus assumes the mantle of a resounding call to action, urging a comprehensive reevaluation of psychiatric practices and an unwavering commitment to amplifying the voices of those traversing the intricate landscape of mental health care.

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