CONF CEP
Understanding Epistemic Injustice, University of Bristol, 26. June 2014 ((als Kolumne gerade oder schräg))

Epistemic Injustice in Psychiatry

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Introduction

Carel and Kidd and Carel's book *Illness* have drawn attention to epistemic injustice in physical illness.
My main claim: people with mental disorders suffer even more epistemic injustice than people with physical illnesses, who are more likely to get sympathy and admiration while psychiatric patients often evoke fear; people in long-term psychiatric care may even be deleted from the family history

Sources of epistemic injustice

Two sources of epistemic injustice in people with mental disorders: global and specific

1. Global sources of epistemic injustice

A. Accumulation of sources of epistemic injustice

Problems of psychiatric patients in addition to the mental disorder itself which are associated with negative stereotypes:
poor education
poverty
social isolation
drug and alcohol dependence
physical illness e.g. antipsychotic drugs causing cardiovascular problems and diabetes mellitus
Negative stereotypes associated with these problems:
it's their own fault, they are dropouts, lazy, lack will power, become ill because of their lifestyle, etc
Consequence of the negative stereotypes:
Many think that the burden on taxpayers of benefits for those with mental disorders should be reduced; politicians who are eager to find ways of saving money know that most of their voters will not press for more resources for mental health services

B. „Soft"/subjective and „hard"/objective evidence

The latter is mainly unavailable in psychiatry.
It enables doctors to control patients as only doctors have access to the hard evidence and the knowledge to interpret it.
Psychiatrists also stigmatised:
Psychiatrists have a medical training and are indoctrinated to place more value on "hard"/objective evidence too. Many of them pay lip service only to the 'biopsychosocial model'; biological orientation increases their status with

medical colleagues and in the general population if, for example, they talk about ‘chemical imbalance in brain’ which can be remedied by such-and such a drug.
Because psychiatrists are stigmatized, there is a problem of recruitment, medical students often preferring to go into more glamorous, high-tech specialities e.g. cardiology.
Need for more “virtuous hearers” who have a greater aawareness of epistemic injustice:
Changes in medical training, e.g. Balint groups for students,
qualitative, not just quantitative research
interpersonal ‘dynamic’ meetings for members of multidisciplinary team

C. Social stigma of mental disorders

- two fears associated with mental disorders
    - Fear of being ‘infected’ by mental disorders
    - Fear of having to cope with irrational, unpredictable and possibly violent behaviour (may be based on a dim awareness of one’s own irrationality and aggressive thoughts/actions
- effects of stigma: Psychiatric in-patients not allowed to register to vote until 2006
- negative effects on prevention, early intervention and treatment of mental disorders
- self-stigma leading to lack of epistemic self-confidence and giving up life goals
- structural stigma leading to discrimination, e.g.
  10% of NHS morbidity 20% of NHS budget
    - acute psychiatric beds cut
    - Richard Layard and CBT

2. Specific sources of epistemic injustice

Dementia

- definition
- rare but treatable causes should be excluded
- negative stereotypes: global intellectual impairment; need for neuropsychological testing and treatment, and for capacity assessment

Schizophrenia

- cognitive impairment, esp. executive function
- negative stereotype: unpredictable and violent behaviour based on split personality eg Jekyll and Hyde, Norman Bates in Hitchcock’s Psycho

Conclusions

- Psychiatric patients suffer even more than medical patients from epistemic injustice

- Remedying epistemic injustice may require not only more “virtuous hearers” but collective social and political change e.g. reducing stigma in media, fairer distribution of financial resources in favour of mental health services