Psychological Medicine

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Cite this article: Grim K (2023). Correspondence. *Psychological Medicine* **53**, 5876–5878. https://doi.org/10.1017/S0033291723000752

Received: 13 February 2023
Revised: 22 February 2023
Accepted: 6 March 2023
First published online: 14 April 2023

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To the editor

In a recent editorial, Kious, Lewis, and Kim (2023) review literature on epistemic injustice in psychiatry, concluding that practice adaptions in response to allegations of EI should be discouraged and may even be detrimental. They present excerpts from a handful of publications that, according to their authors, exemplify EI in psychiatrists' contacts with patients. They examine each example and clarify why they find the allegations of EI to be unfounded.

I will not scrutinize their analyses of their sample of cases, but rather recommend a comprehensive review of the literature before reaching a general conclusion that most claims of EI in psychiatry are unsubstantiated. Not least, I want to highlight findings from studies colleagues and I have performed on shared decision-making (SDM) in the psychiatric context. For us, the theory of EI has provided a valuable tool for exploring interactions between service users and providers, illuminating hindering and facilitating conditions for translating policy on user participation into practice.

SDM is widely recognized as an essential element of a person-centered, recovery-oriented psychiatric care (Matthias, Salyers, Rollins, & Frankel, 2012; Morant, Kaminskiy, & Ramon, 2016). Creating conditions whereby the knowledge perspectives of service users are legitimized in care planning is considered crucial. However, service users frequently report on negative experiences from encounters with providers, describing how not being regarded as credible due to their psychiatric conditions constitute a key barrier to joint deliberation, an issue that is commonly identified as an urgent matter for further inquiry and understanding (Crichton, Carel, & Kidd, 2017; Kurs & Grinshpoon, 2018).

The analytical reasoning in some of the studies Kious et al. (2023) have included in their review has inspired our analyses and resonates with our discoveries. In my view, these studies convincingly illustrate how psychiatric patients are particularly vulnerable to EI in their healthcare contacts and provide valuable guidance for addressing and overcoming EI in the psychiatric context. In harmony with the findings of Sanati and Kyratsous (2015), our interview studies involving psychiatric service users and providers (including psychiatrists, psychiatric nurses, and psychologists) highlight how capacities of insight and decision-making competency might certainly be impaired during periods of acute illness but that these, often temporary, lowered capacities may lead to global attributions of irrationality.

In our studies, service users referred to various kinds of information they wanted to bring to the table in decision-making processes. Many had lived with illness for long periods but noted that while personal knowledge on e.g. self-help strategies and early signs was often relevant when choosing among different options, it was rarely requested or considered (Grim, Rosenberg, Svedberg, & Schön, 2016, Grim, Rosenberg, Svedberg, & Schön, 2017).

However, our findings do not reflect a unidimensional representation of reality in which one group subjects the other to injustices, but rather reveal a complex set of covert mechanisms in provider–user contacts. Analyzing users' and providers' narratives collectively helped to unravel epistemic dynamics at play in interactions between these groups (Grim, Tistad, Schön, & Rosenberg, 2019). Both groups perceived how users constitute a group exposed to epistemic challenges. However, even when the two groups described similar issues, they tended to understand them differently.

In our studies, service users commonly noted how they took a passive role or edited communication due to power differentials. Some described how they chose to stay silent from previous negative experiences of not being ascribed credibility. Some noted how they modified their communication in order to increase the likelihood of being liked and listened to, or of fear of not being cast as a 'difficult patient' if they seemed too assertive (Grim et al., 2016, 2017, 2019). Applying EI theory, such strategies, where a speaker edits communication to be able to deliver their message or to avoid negative consequences, can be understood in terms of testimonial silencing (Blease, Carel, & Geraghty, 2017).

Providers commonly commented on users' incapacity or lack of decisiveness for active participation, sometimes noting difficulties in getting users to speak. This silence was commonly understood as unwillingness to participate (Schön, Grim, Wallin, Rosenberg, & Svedberg, 2018). Other providers, however, acknowledged how service users tended to hold back from voicing to their concerns and wishes because of feelings of dependency and insecurity in the face of authority. The risk

https://doi.org/10.1017/S0033291723000752 Published online by Cambridge University Press

was noted, by users and providers, that providers might misinterpret this silence as complacency (Schön et al., 2018).

Frequently, providers highlighted the complexity involved in balancing conflicting values of patient autonomy and of safety and professional accountability. Their comments implied how a protective stance took precedence by e.g. shielding users from the confusion and anxiety that can be caused by excessive information-sharing and multiple options (Schön et al., 2018).

Consistent with other researchers (Torrey & Drake, 2010), our findings show that users' ability and preferences as regards decision-making are not static qualities. Aligning levels of participation with levels of insight and capacity is consistent with principles of person-centeredness (Chan & Mak, 2012; Chong, Aslani, & Chen, 2013). However, in relation to assessments of capacity and motivation, and equally congruent with previous findings (Shepherd, Shorthouse, & Gask, 2014; Younas, Bradley, Holmes, Sud, & Maidment, 2016), a key observation was that providers often tend to be unduly pessimistic.

As for hermeneutical injustice, our studies corroborate previous research, highlighting how diagnostic, symptom-focused practices do not readily allow for holistic perspectives and personal narratives (Kurs & Grinshpoon, 2018). Service users noted how important aspects of their lives stories, their strengths, vulnerabilities, and social lives remained unexpressed or were lost in communication due to time restrains and inflexible formats for information sharing. Notably however, some users expressed how medical modes of explanation were vital for decision-making. Indeed, in some cases, an overemphasis on social factors had led general practitioners to fail to refer to specialist care for diagnosing and initiating treatment, causing years of unnecessary suffering.

Some users expressed frustration over lacking conceptual tools to articulate or understand their, often diffuse and multifaceted experiences, or to comprehend what providers say about their conditions. Many commented on difficulties in understanding the psychiatric terminology, wishing for providers to use a more ordinary language (Grim et al., 2016, 2017). However, some users appreciated how the conceptual scope of medical knowledge had *added* to their hermeneutical resources in that it provided the tools required for comprehension, manageability, and communication (Grim, Rosenberg, Svedberg, & Schön, 2017).

An important manifestation of hermeneutical injustice, identified in our studies, involved users' experiences of being misinterpreted and having little control over how their problems were categorized and documented. Many noted how their illness was conceptualized as chronic, and how lack of recovery-knowledge within the health care systems caused outdated labels of dysfunction to be stuck on them and follow along in providers' understanding of them (Grim et al., 2016, 2017).

In view of these phenomena clarified through the analytical lens of EI, I propose that professionals within psychiatric systems indeed may benefit from acknowledging EI in analyzing and developing practice. The cases made here calls for a general shift in attitudes, toward the key assumption of person-centeredness that people have capacity and determination with respect to decisions that directly affect their lives. Credibility judgements need to be nuanced and graded to avoid the testimonial injustice of dismissing testimonies without thorough examination of their trustworthiness. As phrased by Buchman, Ho, and Goldberg (2017) in their advocacy for epistemic justice, providers need to adopt a default attitude of trust in users being capable epistemic agents, with a readiness to lower expectations of epistemic capacities only when a need of such a stance is evident.

Constant mindfulness is needed of the power embedded in professionals' roles and interpretive prerogative and of users' experiences of having to struggle and to edit their interactions to be considered a likable and worthy interlocutor. Atmospheres of increased trust may be established by communicating to users that any views, accounts, or questions may be expressed without risking being labeled as difficult. The constructive element in categorizing and documenting needs to be acknowledged, necessitating readiness to involve users in defining their own needs and predicaments.

In Sweden, the concept of EI has been increasingly applied amongst academics, quality developers, and policy-makers in the psychiatric context, for clarifying mechanisms vital to address in order to comply with policy for person-centeredness and user participation. Moreover, EI has been embraced by user organizations as it illuminates and puts into words a fundamental base of user's experiences, thereby contributing to empowerment and hermeneutical justice.

In a recent co-produced study where user and system representatives participated in workshops, a team of researchers and service-user representatives applied EI to explore barriers to user-knowledge integration in service development and provision (Grim et al., 2022). We are currently developing a pedagogical material based on these research findings, aiming at supporting epistemically just user involvement endeavors.

Accordingly, while Kious et al. (2023) propose that heeding calls to counter epistemic injustice in the psychiatric context entails risks, I suggest, on the contrary, that it is risky to dismiss the theory's value for practice on account of a partial review.

Conflict of interest. None.

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