Lost in Translation? Clinical knowledge, epistemic injustice and mental health patients.

(Draft: this is a work in progress)

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Abstract

In this paper I will first present an ethnographic vignette drawn from anthropological fieldwork in NHS mental healthcare settings in Oxfordshire and Buckinghamshire. This describes a patient, Jonathan, who discussed with me how some intensely felt and deeply meaningful personal experiences led to him being sectioned and how his care team frame these experiences in a very different way. I then use Miranda Fricker's work on hermeneutical injustice to consider: (1) is this a case of hermeneutical injustice; and (2) does Fricker's work help us understand something about Jonathan's experience of mental healthcare and more generally, the relation between mental health clinicians and patients. I find that the notion of hermeneutical injustice is successful in interpreting an aspect of the harm done to patients and I note continuities between this and characterisations of harm in the anthropological and service user research literatures. However, for Fricker, power remains as a slightly abstract quality, focussed on identity prejudices. My ethnographic material supports reference to institutional processes as shaping knowledge in particular ways.

1. Jonathan

I met Jonathan in day hospital. He had been detained under the mental health act and was permitted each morning to walk down the hallway that connected the ward and the day hospital. Jonathan came across as a very intense young man, serious, and committed to intellectual enquiry, though by no means without a sense of humour. He was originally from the north-east of England and had come to Oxford for graduate work. He seemed quite pleased to have the opportunity to talk with someone whose academic background resembled his own. Almost as kindred spirits, we spent many hours chatting.

In some respects Jonathan was quite upbeat. He was lively and intelligent in conversation, attentive to my remarks and creative and thoughtful in his responses. Although some of the patients in the day hospital were withdrawn and taciturn, we would laugh and joke together, recalling funny incidents from TV shows we both enjoyed. Jonathan proposed a comical medical vocabulary of his own to make fun of the hospital setting and its tendency to medicalise, such as 'biscuit deficit disorder' 'tea-and-coffee based outcome measures' and 'coffee spoon mood tracking.' Sometimes it seemed like the worst problem he had was that the hospital restricted his smoking.

Nonetheless, there was a darkness about him. He said he felt the world was ‘absurd’ and ‘meaningless.’ To him there seemed no way of bringing real value to life. He found day to day experiences not impossibly painful, but, rather, effortful, demanding and unsatisfying. They created a kind of cumulative burden oriented both forwards and backwards in time. Negotiating his way through the empty days to reach the present had been exhausting and he felt weary just thinking about the unspent days piled up in front of him. He had been reading a lot of Russian literature, which only seemed to confirm his fears. It was a ‘mistake,’ he said, ‘to think that life was worth living,’ a mistake arising out of ‘superficiality,’ distractedness arising out of work, dating and the like, or ‘bad faith.’ None of these were mistakes he wanted to make. So he wanted, in his words, ‘to be gone.’ However, his nihilism was not total. He also wanted ‘to go’ in such a way that his leaving reflected his philosophy of life. He explained that he had tried to stab himself in the heart at midnight in the centre of the Rollright Stones. He had bought a large carving knife in a shop in Oxford, then hired a car and driven out to the ancient stones. However, the stabbing had gone wrong, he had become distressed, been spotted by some passers-by and he had ended up on a section.

This was a grand and terrible gesture. I found it very distressing but also slightly melodramatic. ‘Stabbing myself in the heart’ seemed to be an idea, or perhaps a sentence, that he was deeply attached to, even if the reality was harder to pull off. He said he ‘couldn’t get the blade in’ a problem that hadn’t come up on the many occasions he envisaged the act. He was now bandaged over his chest. I remained unsure of how to understand his actions. Our conversations just added to my uncertainty. There are clearly simpler and more reliable ways of taking your own life. This was more than just an attempt to be gone. Was the stabbing a ritual? A piece of theatre? Perhaps an artwork? How serious was it, both as a gesture to be understood and an attempt to end his life? Jonathan spoke of being ‘heartbroken by the world.’ Was this a tragic but also ironic commentary on his grief? An absurd expression of despair intended for an absurd world? An act of sacred meaning that gained significance by being ignored or misunderstood, because heedlessness and insensitivity were intrinsic to the world and drivers of despair? I felt he had a sense that it might have looked rather good in an arthouse film. But, over our conversations, as we explored the multiple hermeneutics of the stabbing, I found that he too was unsure of how to interpret the stabbing and was exercised by the question. What did seem clear from our conversations was that Jonathan was having a personal crisis, that it was deeply meaningful, and that it was driven by sophisticated ideas, powerful and complex feelings and ethical intuitions.

Jonathan found he was not able to discuss the meaning of his actions with staff members. Instead, he was quietly enraged as the way they framed his experiences stood in stark opposition to, and seemed to silence, his own framing. I didn’t observe his interaction with his psychiatrist, but had observed the same psychiatrist on other occasions talking in the way that Jonathan described. I did observe Jonathan’s interactions with nurses in day hospital, including during various psychoeducation classes. Jonathan explained that he had been told that he was experiencing depression and anxiety, not profound feelings of existential dread. For staff, this was a biological event located in the brain, rather than an idea, or an insight, or a matter of ethical commitment, or, even, some kind of puzzle to be worked through. There was an element of mystery to the staff, in that the neuroscience was not yet fully known, but it was otherwise unitary and comprehensible. In contrast, for Jonathan the stabbing was rich, expressive, meaningful and susceptible to multiple interpretations. He had hoped that the liminal vantage point of the hospital would be a good setting in which to get a sense of what was going on. In our conversation there seemed something fitting about the complexity and ambiguity of the stabbing. One the one hand, it seemed that the complexity of the act matched the complexity of the problems it referred to. On the other, the hermeneutical struggle it presented seemed itself to be a potentially therapeutic process.

Jonathan took exception to the categories of depression, anxiety and mood. This caused some tension with nursing staff who ran psychoeducation classes in which these categories are foundational. Jonathan didn't think he was depressed. He had looked up clinical definitions online and found them simplistic and unable to describe his states of mind. He pointed out that in many respects he was quite cheerful, that he, 'like everyone else you know' can 'accommodate a diversity of feelings.' In 'psychoeducation' classes that taught patients about low mood and high mood, he was something between a conscientious objector and a dissident, discussing how not all feelings can be valanced as positive or negative or expressed as quantities. He said that to frame the difficult feelings he experienced as 'depression,' 'low mood' or 'anxiety' missed the point. Much more nuanced categories were required, such as 'alienated,' 'ennui,' and 'dread.' These feelings, he thought, signified problems, but were not in themselves problems to dealt with, but part of a valuable process that, as it comes to an end, would yield insight. For the nurses it was a trying experience, but not unfamiliar. They allowed him to 'air his views' but didn't want him to 'get in the way of the session.' At times they described him as 'not understanding,' as 'having his own ideas' and as 'not engaging.' Jonathan was unimpressed. 'They want to turn me into a moron' he said.

For staff, the stabbing indicated 'suicidality.' It's significance was in relation to the act of suicide and the risk he presented and these were the topics they wanted to talk about. Other than this, it had no meaning or value. Jonathan's ideas were instances of 'suicidal ideation.' This is a form of words that comes up a lot in mental healthcare. I found that when staff members used the word ideation, it suggested pathological thinking, inferior to normal thinking. The notion of ideation undermines thoughts by connecting them with disorders. Framing ideas as 'suicidal ideation' meant these were not ideas in the best sense but a kind of second class idea that, could comment on the thinker's subjective state but otherwise didn't amount to much. It occurred to me whilst chatting with Jonathan that it would seem strange, perhaps even aggressive, to call the deliberations of psychiatrists 'clinical ideation' or 'diagnostic ideation', because calling something ideation undermines its credibility.

The clinical sense of temporarily also clashed with Jonathan's. They saw the stabbing as indicative of long-term problems, even of a disorder that will last a lifetime. The stabbing was a crisis in the sense that processes that had been going on unnoticed had now come to light in a dangerous but revealing way. Staff members were keen to remind Jonathan that he had to take medication that, over time, would 'correct' the problem. His role was to sit tight, keep himself safe and, if he wanted to, track the ups and downs of his 'mood' using a selfrating technology that measured how he was doing and presented it on a graph. Jonathan's sense of crisis was rather different. He felt the stabbing was one of the most important moments in his life. He thought it might be a 'turning point' or 'sea change.' Certainly not just an upturn in low mood.

2. Is this a case of hermeneutical marginalisation?

In what she calls the central case of hermeneutical injustice, Fricker discusses the case of Carmita Wood, as described in Susan Brownmiller's memoir *In Our Time* (Fricker 2007). According to Brownmiller, Wood had worked for eight years in the Cornell nuclear physics department, first as a lab assistant and then administrator. Throughout this time male colleagues would behave in an unprompted sexualised way with her. They would 'jiggle' their 'crotch' or 'brush up against her breasts.' At a Christmas party she was cornered in a lift and had kisses forcefully planted on her lips. The resulting stress led to ill health. Ultimately, she had to quit her job. She wasn't entitled to unemployment benefit because she was regarded as having voluntarily left her job. But in conversation with other women, she found immediate recognition of her experiences, a realisation that they were not rare, and that her response was understandable and justified. They came up with a term they hoped could capture these experiences: 'sexual harassment.'

For Fricker, the category 'sexual harassment' fills a lacuna in our collective hermeneutical resources. 'Sexual harrassment' links the events together and frames them such that they are intelligible. Without the category, Wood found herself unable to make sense of her experiences. This put her at a 'cognitive disadvantage,' or in a state of 'cognitive disablement.' This is harmful: 'The cognitive disablement prevents her from understanding a significant patch of her own experience: that is, a patch of experience which it is strongly in her interests to understand, for without that understanding she is left deeply troubled, confused and isolated…and this, in turn, prevents her protesting it, let alone securing effective measures to stop it' (ibid: 151). As the injustice done to Wood is epistemic, it is addressed by creating new forms of knowledge. Fricker suggests a generic definition that captures hermeneutical injustice per se: 'The injustice of having some significant area of one's social experience obscured from collective understanding owing to hermeneutical marginalization' (p 158).

However, for Fricker, not all hermeneutical disadvantage is epistemic injustice. She gives an example of disadvantage that is not injustice. This is a person whose social behaviour is affected by a medical condition that is not understood. The lack of understanding might put her at a disadvantage, in that others may not understand her behaviour. This lack of understanding may be distressing and may lead to serious consequences. But it is a case of epistemic bad luck, rather than injustice. This is because Wood's disadvantage arose out of women's social powerlessness rather than a general lack of knowledge. As soon as Wood spoke to other women, she found understanding and recognition. The problem wasn't that women didn't know about the experiences she had had, but that this understanding wasn't reflected in language available to Wood because of the subordinate social status of women.

The way that Fricker characterises this is through the notion of 'hermeneutical marginalization.' At the time Brownmiller describes, widespread prejudice against women, and womens' powerlessness relative to men, meant that their testimony was treated as less credible and they were excluded from collective meaning making such that expressive gaps open up. So the disadvantage Wood faced in understanding her experiences arose out of hermeneutical marginalization. And if Wood had tried to convey her experiences, this would be likely to be met with trivializing framings that further undermined her credibility, compounding the injustice.

Does Jonathan's plight in day hospital constitute an example of hermeneutical injustice? I suggest the answer is yes. There are two interpretations of the stabbing. On the face of it, Jonathan's is richer and more nuanced that the care team's. Where Jonathan saw meaning and profundity, the psychiatrist saw mis-firing neurons. Jonathan felt he was going through a crisis, whilst the psychiatrist saw long term disorder. In psychoeducation, Jonathan was taught about mood scores, depression and anxiety. But in his own account, he experiences ennui, dread, ironic humour, despair. There appeared to be no hermeneutical reciprocity in his dealings with clinicians. Staff members do not engage with Jonathan's hermeneutic but impose their own. Their knowledge is constructed in such a way as to undermine his account. He is clearly being placed at a hermeneutical disadvantage. I think it is fair to say that Jonathan's experience of mental healthcare was to a large degree a struggle against unequal hermeneutical participation. In return, services were didactic and epistemically coercive.

One possible argument against this counting as hermeneutical marginalization might be that the team were justified in disregarding Jonathan's understanding. If this were the case, then, in Fricker's terms, their position would not be 'unwarranted.' For example, if Jonathan's ideas were flawed in some way, such that they were incoherent, or known to be misleading, the care team might have good reason not to engage with them. However, over the weeks I saw Jonathan I never saw any signs of him being confused, or muddled, or psychotic. He was highly articulate, reasoned at least as well as I did, and drew on a substantial intellectual hinterland. He did not appear to have beliefs that could count as delusions or sensory experiences that might be hallucinatory. I did not feel he had a convincing and comprehensive account of his actions and neither did he. I took it as a sign of his hermeneutical capacity that he was alive to the polysemic nature of the stabbing (and, conversely, a hermeneutical limitation of the staff that their account was unitary and straightforward). But I could see no intellectual reason to automatically prefer the clinical hermeneutic.

But is this simply a case of epistemic bad luck? I would think that Jonathan's hermeneutical marginalization is also hard to contest. Jonathan is powerless as a result of his status as a patient. At best he has lay knowledge. In clinical appointments he told me that his interpretations of the stabbing and wider pessimism it relates to (that is: his most significant thoughts) are dismissed as 'ideation' and devalued by a rhetorical association with mental dysfunction and disorder. His critiques of psychoeducation, however cogent, are downplayed, and sometimes reframed as a lack of engagement. In contrast, the clinicians who surround him are experts, highly trained people whose testimony can be definitive in legal contexts, and who are gatekeepers necessary, if not sufficient, for access to state benefits, for example. Their knowledge displaces and erases Jonathan's own because they have the power to do so.

There might be a second, pragmatic, reason why the hermeneutical asymmetry between Jonathan and his care team could be defended. That would be if the treatments associated with the clinical view were more effective than those associated with Jonathan's view and that these ends might be held to justify the injurious means. In this case, attending to Jonathan's account might undermine the treatment. The epistemic coercion Jonathan experiences might be in his best interests. This position rests on a number of claims: that the treatments work; that coproducing knowledge would threaten this; that other treatments don't work so well; that the harms of epistemic injustice are outweighed by the benefits of treatment. It doesn't deny that Jonathan is treated unjustly, only argue that it is worth it.

I would want to add a remark here. The notion of hermeneutical injustice refers to an expressive lacuna. Because of it, people can't express or understand their experiences. I did understand Jonathan. He was not completely silenced. On the contrary, he was highly articulate, and able to render intelligible his experiences in an impressive way. He was more hermeneutically confident and able than most patients in the day hospital. Jonathan is highly educated, and has an independent disposition. He is more capable than most to create an account of his experiences despite the hermeneutical disadvantages. This makes him a good example in that he points to the many other cases where the patient is more completely silenced. We don't know what knowledge might be coproduced if Jonathan and his care team engaged as equal partners. We can see that Jonathan is hermeneutically marginalised, in the sense that his account is treated with no credibility because of his identity as a patient and clinical identities as expert knowers. But we can't detect unknown unknowns. There may be an as yet an uncreated category as powerful as 'sexual harassment' that might unlock crucial aspects of his experience. In the meantime, none of the expertise and experience of the care team helps Jonathan make sense of his experiences. We can only guess at what is lost because of this.

3. How can the notion of hermeneutical injustice help us understand the harms of being a patient?

Part of what Fricker's work brings to this case is that an injustice is being done to Jonathan as an integral part of his healthcare. To reject his account is to wrong him. Staff reject his account as a part of their clinical work. They are unable to hear him, because it would interfere with their work. This leaves Jonathan cognitively disabled, and , rather like Carmita Woods 'deeply troubled, confused and isolated.' The harm has a reflexive quality. The lacuna that affects Jonathan's hermeneutic of his distress extends to his experience of injustice. He told me, repeatedly, that staff didn't listen, that his version of events shouldn't just be ignored, that it was wrong of them to treat him like this. He said he felt it was unjust. This seemed impossible to communicate to staff. I think he mostly kept quiet about it, but I did observe occasion when he tried to express his sense of injustice, only to find staff members saying things like: ‘I know this must be frustrating,’ I know this is difficult experience’ but never really doubting that their knowledge was authoritative and exclusive and that convincing Jonathan of this was part of their therapeutic work. Sometimes staff would talk about literature to try to make their point, but never in a way that acknowledged Jonathan’s superior expertise on this topic. If there were signs of agitation in Jonathan, my sense was that staff thought this might be symptomatic of his disorder – ie be connected to depression and anxiety – or indicate ‘poor insight’ or ‘poor compliance.’ These events seem to be counterparts to strategies to trivialise Woods experience of sexual harassment, for example by accusing her of asking for it or liking it.

Fricker’s distinction between primary harm and a secondary harm helps unpack Jonathan’s suffering. ‘The primary harm of hermeneutical injustice consists in a situated hermeneutical inequality: the concrete situation is such that the subject is rendered unable to make communicatively intelligible something that is particularly in his or her interests to be able to render intelligibly’ (ibid: p162-3). This seems to express Jonathan’s immediate predicament. He wants to try to make sense of his pessimism and the stabbing and is unable to do so. In Fricker’s analysis, this primary harm causes further secondary harms, both practical and epistemic. In the case of Carmita Wood, practical secondary harms include physical ill health and lack of access to unemployment benefits. Here our material diverges from Fricker’s examples. For Jonathan, continued access to mental healthcare or state benefits is not jeopardized by his hermeneutical marginalization. Indeed, it is dependent on its continuation, in that were psychiatrists content to characterise his problems as a ‘spiritual crisis’ say, he would not be eligible for benefits. This has a disciplinary quality, however, in that both healthcare and benefits require a biomedical hermeneutic. Jonathan may be obliged to sign paperwork in which he is described as depressed and anxious to access services. If he is to be released from his section, it will help if he says he accepts the clinical take on his stabbing.

Fricker goes on to make some very interesting remarks about secondary epistemic disadvantages. These disadvantages seem to relate in important and useful ways to service user research and anthropological research investigating how mental healthcare might cause stigma, disempowerment and social defeat. Fricker stresses that the kind of situated hermeneutical inequality that Carmita Wood found herself in is liable to ‘cramp the development of self.’ What this means is that hermeneutical injustice harms by limiting knowledge, diminishing self-confidence. Carmita Woods felt shame and guilt where she should have felt (something like) righteous anger. To illustrate, Fricker discusses Edmund White’s memoir of growing up gay, *A Boy’s Own Story*. As a young man, White faced understandings of homosexuality – that it is a sin, a sickness, that gay men where liable to sexually assault others - that failed to correspond to his own sense of self, but which were nonetheless authoritative, and which obstructed the development of a healthy sense of self. White describes how he tried to resist, and at times fell into a kind of doublethink, both accepting and rejecting accounts. This doublethink is harmful. Fricker suggests, without really developing the point, that it can creates fissures and divisions where a healthy self is unified and integrated. I don't know what the long term effects of mental healthcare were on Jonathan as he returned home to live with his parents and we lost touch. But I was able to discern the development of this doublethink: two dissonant hermeneutics that might create impede his development of self.

These concerns link with wider literature. Researchers and activists from the 'Recovery Movement' or 'Survivor Research' frame iatrogenic harm in terms of patient empowerment and disempowerment. They argue that contact with services can result a loss of empowerment. In a policy document produced by Sitra called *Co-production: It's About Time,* a former patient writes that he or she 'found the experience of being a passive recipient of care dehumanising, disempowering and disenfranchising' (Sitra n.d.). He goes on to describe how improvements to his mental health involved resisting or withdrawing from healthcare: 'I started to claw my way back to life with the help of my peers. I started to take the power back that I had all but lost. I started to become a participant in my own recovery. I started to fight against passivity.'

The proposed solution to disempowerment is 'involvement' or 'participation.' Several contributors to an edited volume, *Mental Health, Service User Involvement and Recovery*, make related arguments (Weinstein 2009). Gosling, for example, sees involvement as the best way to reverse the loss of a sense of purpose, and feelings of being unvalued or weak that typically arise in mental healthcare. In a chapter called 'The Ethos of Involvement as the Route to Recovery' Gosling writes that:

> User involvement can also contribute towards recovery in situations where users become part of a team or group…with a sense of purpose. People start to feel depended upon and needed and gain a sense of responsibility. Their expertise, experience and knowledge are recognised and they become aware of their potential to grow and gain new skills…Involvement can help people feel powerful again. (Gosling 2009: 33)

Here, Fricker's work adds theoretical precision to first-hand experience. This sense of weakness appears, in Fricker's terms, to be a secondary epistemic harm. A loss of confidence and agency emerges as a natural result of hermeneutical marginalization. Coproduction is necessary because hermeneutical marginalization is unjust and harmful.

In the literature, this loss of agency is often linked to concerns about chronicity. Anthropologists of medicine have long been concerned that biomedical mental healthcare can be self-defeating and contribute to chronicity. Lurhmann argues, for example, that for people diagnosed with schizophrenia in the US, 'our standard model of care not only does not help but may even make the illness worse' (Luhrmann 2007: 136). There is evidence that for people with severe mental health problems, long term health trajectories are better in non-Western settings and away from biomedical care (Craig et al 1997). One reason might be that thinking of distress in disease categories or in actuarial terms of ‘risk’ and ‘vulnerability’ leads to long-term problems rather than acute crises. We have already seen that Jonathan interprets his distress as a crisis and turning point whilst the care team think in terms of long term disorders and dysfunctions. If personal agency is undermined by hermeneutical marginalization, this might also contribute to chronicity. The notion of ‘institutionalization’ often refers primarily to habit. Fricker’s work encourages us to include epistemic qualities as well, such that our notion of agency should include the epistemic.

In Estroff’s classic ethnography of patient experience, *Making It Crazy* (Estroff 1981). Estroff found the role of mental health patient self-perpetuating. Spending time as a patient – making it crazy – means becoming accustomed to a distinct and recognisable way of life, defined in opposition to the life of non-patients or ‘normals.’ As the years go by, being crazy may not stop being painful, insecure, limited and excluded, but it becomes familiar and comfortable, and thus a source of disability in its own right. Estroff thinks that motivation and willpower are gradually reduced over time, whilst ‘crazies’ feel ever greater anxiety about whether they can ever make it again as a normal. Fricker’s work might add to this account. Estroff observes hermeneutical inequality between staff and patients, but it does not form a major part of her analysis of how the crazy role becomes self-perpetuating. More recent work by Luhrmann on social defeat points to a way of doing so.

In a series of articles developing the concept of ‘social defeat’, Luhrmann makes a more theoretically developed case than Estroff (Luhrmann 2006, Luhrmann 2007, Luhrmann 2008). Social defeat is the subjective consequence of repeated social encounters in which an individual finds themselves demeaned, humiliated, shamed or subordinated (Luhrmann 2007: 151). In a moving ethnographical account of a women’s homeless centre in Chicago, Luhrmann describes the ‘countless small humiliations’ experienced each day by users, accumulating as a burdensome, corrosive, even toxic load (ibid.: 159). A continual sense of being socially defeated leads to anomie, demoralization, humiliation, self-stigma and helplessness.[1] The problems are deeply rooted. The way subjective experiences are conceptualized as psychological obscures the social and political background (Luhrmann 2006: 359). Luhrmann’s informants have lost fundamental preconditions of empowerment: the ability to make decisions and act on them. Indeed, the category of Schizophrenia is so devalued that some homeless women prefer to sleep rough rather than stay in a hostel that requires them to accept the label (Luhrmann 2008: 19). The category of hermeneutical injustice adds to this account. Lurhman’s informants are hermeneutically marginalized and, as a result, find that their capacity to make sense of their lives is undercut by clinical knowledge. They are forced to accept secondary epistemic harms and the identity problems that go with it. Their epistemic confidence is undermined. Clinical

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[1] Whitley found rather less social defeat and rather more vibrant social resistance, albeit in a group of severely mentally people housed in a recovery community (Whitley 2011). More recently Wright has drawn a picture of highly variable levels and varieties of social defeat in a recovery community in Texas, interspersed with occasional personal resistance (Wright 2012).

categories are not only devalued or stigmatizing: Fricker's work helps us see that their limited expressive power combined with their authority and capacity to displace alternate accounts is also a source of injustice and harm, potentially contributing to chronicity.

This points to the need for new forms of coproduced knowledge that bring patients and clinicians as equals into the same expressive space. It also contrasts with the view, dominant in biomedicine, that presents stigma as a consequence of knowledge deficits and false beliefs (Thornicroft 2006). According to this view, education and awareness building are the solution to stigma. I have described how Jonathan resisted psychoeducation. Fricker's work suggests that hermeneutical asymmetry and the limited expressive powers of clinical knowledge cause some of the problems that are classed as stigma. Reinforcing the authority of clinical knowledge is thus only likely to make things worse.

4. Why is hermeneutical injustice occurring?

Fricker's account of power and powerlessness is expressed through examples derived from gender, class, race and sexuality. These power imbalances arise in wide social formations: prejudice, negative stereotypes, stigma and 'bad affective investments' that lead to a kind of inattentiveness and an unwarranted devaluing of the testimony of others. Clinical power in mental healthcare might be a little different from this. That is not to say that wider social processes are not at work. Prejudice against people who seem mad or strange can prevent mutual comprehension and plays out in mental healthcare settings. But I suggest that much of what happened to Jonathan occurred because staff members are struggling to 'deliver' accountable care, which means care based on a small repertoire of clearly defined, mostly measurable terms, linked to scalable treatments, all of which can be documented and justified in an economical way. This narrowing of care is a kind of transformation. It has angered many clinicians who see key aspects of their work – such as creating therapeutic relations, or even in just being kind - swept away. But it makes accountability possible, such that where things go wrong, for example if Jonathan did kill himself, we might have a paper trail to follow and try to learn from. Accountability means that institutions can be scrutinised and their work evidenced. And bureaucratization also creates the conditions for the kinds of documentation required by market mechanisms currently operating in the NHS. Low mood and anxiety are simple, transparent and amenable to bureaucratic working, whilst ennui and dread are not. Jonathan's risk of suicide is legible and highly visible in documentation, whilst his quest for meaning is not. The epistemic injustice he suffers from, and which may have long term ill effects, arise not so much out of clinical power or prejudice but more out of very understandable and apparently overwhelming efforts to make care accountable. Efforts are coproduction are thus likely to meet institutional barriers.

My ethnographic experience suggests that many clinicians are unhappy with these trends. They complain that they can't develop relationships with patients, that they are forced to use decision trees or other technologies that constrain and routinize their work. Off the record, may doubt the trials and studies that provide the evidence base fo this kind of care. Indeed, some say they feel it is no longer possible to do the job, and that they doubt what they do now is of much help. These views are heterodox. They are not discussed openly. Indeed, staff too seem to be developing a kind of doublethink, perhaps leading to the staff retention problems that seem to be close to a crisis levels in NHS mental healthcare.

This institutional dimension to epistemic injustice is not discussed by Fricker although she touches on these related briefly in her account of systemic and incidental injustice. But in her monograph, she quotes Nancy Hartsock in a way that relates to these issues: ‘The dominated live in a world structured by others for their purposes – purposes that, at the very least, are not our own, and that are, in various degrees, inimical to our development and even existence.’ (Nancy Hartsock The Feminist Standpoint Revisited and Other Essays 1998: 241 quoted in Fricker 2007: 147). This seems to fit my material. Whilst he was detained in the hospital and treated with powerful medications against his will, Jonathan was forced into a word structured by others for their own interests. But those doing the structuring, the clinicians, themselves are dominated, and find themselves half convinced and half coerced into an epistemic and moral world of treatment that is accountable, but epistemically unjust.

Conclusion