Excluding Experts in Inclusive Practice: Epistemic Oppression and Existent Barriers in Coproduced Approaches to Mental Health

A J S WILDE
PhD 2025

Excluding Experts in Inclusive Practice: Epistemic Oppression and Existent Barriers in Coproduced Approaches to Mental Health

ALANA JESSIE SHEPHARD WILDE

A thesis submitted in partial fulfilment of the requirements of Manchester Metropolitan University for the degree of Doctor of Philosophy

---

Department of History, Politics and Philosophy
Manchester Metropolitan University

2025

Abstract

This thesis provides an understanding of the ways in which those with lived experience of mental ill health try, but often fail, to affect shifts in our scientific understanding in coproduced research. Such failure, I argue, is best understood as a kind of epistemic oppression. This is because, I argue in line with Morten Byskov's (2021) extension of Miranda Fricker's (2007) account of epistemic injustice, there is reason to believe that lived experience may, in the right circumstances, give rise to a kind of expertise: expertise by experience. And individuals with lived experience are invited to take part in coproduced research principally because of their acquaintance with mental ill health. Failure to heed their knowledge, can then be understood as undermining such experts by experience in their capacity as knowers.

I argue that several accounts of epistemic injustice fail to adequately explain the phenomena that this thesis considers, though note that whether a theory is deemed apt for our purposes will depend upon what we are attempting to make sense of. Giving a preference for a systemic understanding of the injustice I consider, I apply Kristie Dotson's (2014) framework of *third order epistemic oppression* to coproduction. This view neatly allows us to see that stigma, power, and what one wants to contribute to shared understandings all play a role in whether one can be taken seriously. The polarization of pre-theoretical commitments as they relate to psychiatric medicine, I lastly consider, makes the task of taking experts by experience at their word, however, challenging to say the least.

Acknowledgments

This thesis has been an extremely long time in the making, and as such, the list of people without whom it would not exist is not a short one! First and foremost, thanks must go to Anna Bergqvist, and David Crepaz-Keay for their warmth, insight, and supervision over the past few years during the course of this PhD. Thanks too to the committee members I have had throughout this PhD programme, Matthew Barnard, Paul Giladi, Wahida Khandker, and Rosamund Oates, your insights have undoubtably made this thesis better.

I have been incredibly fortunate to also have had the opportunity to work with incredible, and supportive supervisors and mentors at The University of Sheffield, and The University of Virginia, and so thanks too must go to Jenny Saul and Elizabeth Barnes and also to Rosanna Keefe, Chris Bennett, Jimmy Lenman, Antonia Lolordo, and Rebecca Stangl. In the philosophy community more broadly, I am incredibly fortunate to have connected with a number of academics, discussions with whom I will remember for a long time. Whilst I undoubtably will have forgotten someone here, I'd like to mention specifically Jo Stramondo, Eva Kittay, Zachary Irving, and audiences at the UNC Chapel Hill 3rd Biennial Conference on the Philosophy of Disability, and the Royal Institute of Philosophy Festival of Philosophy session. All of you in some ways have made, and continue to make, philosophy a better place to be.

The PhD and early-career community I have found to be an extraordinarily supportive, collegiate, and most importantly, welcoming network. And so, to my friends both within and outside the academy, thank you for your enduring support. Thanks here go to Matthew Andler, Emma Bolton, Elyse Cavell, Alex Cocker, Matthew Cull, Kayleigh Doherty, Anna Kleiber, Stephen Marrone, William Morgan, Robbie Morgan, Maya Tucker, Phoebe and Ben Wallace and Rosa Vince. Special thanks to Matt, Rosa and Maya for being an enduring source of encouragement, and believing that one day this thesis would be written, even when I did not.

I am incredibly lucky to have also had unwavering support from my parents, Alison and Dean, and my siblings, Adam, Bea and Thomas. Though philosophy is not where any of them find joy, they have remained supportive, interested, and always willing to make me laugh by asking a question which is definitely *not* philosophy!

Thank you, to all of you.

Lastly, I would like to thank my funders, the North-West Consortium Doctoral Training Partnership, for supporting this collaborative doctoral award, and for additional financial support for the RIP festival. Thanks also go to the Royal Institute of Philosophy, who published the proceedings of that festival as a conference supplement, including arguments from chapters three and four of this thesis.

Table of Contents

Introduction

> "… *survival is not an academic skill*. It is learning how to stand alone, unpopular and sometimes reviled, and how to make common cause with those others identified as outside the structures in order to define and seek a world in which we can all flourish. It is learning how to take our differences and make them strengths. *For the master's tools will never dismantle the master's house*. They may allow us to temporarily beat him at his own game, but they will never enable us to bring about genuine change".
>
> Audre Lorde, 1984: p112.

This thesis provides an understanding of the exclusion of experts-by-experience in coproduction as a kind of *epistemic injustice*. Moreover, it provides that understanding in ways which diverge from much of the extant discussion of epistemic injustice, by arguing that, following Kristie Dotson, we ought to best make sense of this particular kind of epistemic harm as a sort of *epistemic oppression*. Much discussion has taken place over recent years relating to epistemic injustices that arise based on a number of characteristics one might have. Here, my focus is a necessarily narrow one, as I am particularly interested epistemic injustice as it relates to those with lived experience of mental ill health. In fact, many of my discussions are narrower still than that, insofar as I am interested in a puzzlement presented by an ever-evolving research methodology: coproduction. The promises of coproduction (as I'll discuss in Chapter One) are great. In short, it aims to flatten traditional researcher-researched hierarchies, and to share the power for knowledge generation amongst those we traditionally expect to see in the clinic, with the individuals who might otherwise have been their patients. As I'll outline, though, this research methodology is fraught with difficulty; this is because it remains situated within paradigmatic research traditions. This results, I will say, in coproduction failing, oftentimes, to give due credence to those voices it seeks specifically to include. I will argue that the very epistemologies which research aims to contribute to, preclude those with mental ill health from being able to prompt changes to our accepted understandings. They are, therefore, likely to experience epistemic oppression in circumstances where their views diverge from the traditionally held views in either the medical tradition, or the academy. Thus, the Lorde quote above gives you, the reader, a sense of what is to come.

In addition to the novel application of Dotson's theoretical framework, this thesis also makes further contribution to the literature basis, by exploring the possibility of patient expertise – expertise by experience. This, I'll claim is a central tenet of being able to argue for any sort of epistemic injustice at all; as, if patients do not possess relevant expertise, then we should not allow their insights to prompt changes to our research projects. Here again, I diverge somewhat from others in social epistemology, as I claim that there are instances whereby we would be epistemically prudent *not* to take seriously the claims of an individual with experience of mental ill health, and that, in fact, we may cause offence in such cases, but those cases are not ones we should rightly consider epistemic injustice.[1] I will argue, though, that patient expertise derived from experience, is a concept that we should take seriously. I'll argue that many such experts by experience, in mental ill health, are likely to experience epistemic injustices.

To situate this thesis appropriately as a work of philosophy, it is important to note that whilst many of the philosophical theories upon which I rely originate from the tradition of social epistemology, I consider my arguments to also be situated within the feminist

---

[1] Whilst it may seem as though this point is a criticism of those who do not consider *whether* we ought to take seriously some individual or other in applying the concept of epistemic injustice, this is not my intention. Oftentimes, simply being a member of, or even being read as a member of, a particular group about whom there exist pernicious stereotypes is sufficient to have such stereotypes affect you. My divergence here relates to the notion of *expertise*, which is necessary for my purposes, because the cases I consider almost exclusively arise when an expert-by-experience disagrees with an academic or clinical expert. To avoid side-stepping questions of epistemic injustice altogether, and claiming deference to traditional expertise then, it is important for my purposes to consider whether we *should* believe those we dismiss. This is not a step necessary for all accounts (for instance Crichton, Carel and Kidd, 2017; Kidd and Spencer, 2022).

philosophy tradition. With that in mind, and in the spirit of ensuring that talented voices are not overlooked merely because they are not ordinarily considered part of the philosophical *canon*, I have purposefully chosen to use literature, where it exists, from marginalised individuals in the philosophy community. This, at times, means that I do not introduce the work of much-discussed scholars, where it might perhaps seem as though I may have done so. This choice is one I have made intentionally. In discussing a marginalised community (those with mental health conditions), whose knowledge often fails to make it into our shared spaces, it felt inappropriate and misguided to overlook voices we often do not hear in academic spaces. And, whilst this is a work of philosophy, it is indeed also a work which draws upon many other scholarly disciplines and borrows quite heavily from psychiatric, nursing, disability, and public policy research, in illustrating many of the points made. Coproduction is still a relatively new – philosophically speaking – way of doing research, and coproduction in the realm of mental health more so. As such, it would not have been possible to make the arguments in this thesis alone without drawing on the work of colleagues from across the academy.

Terminology and approach

At times, the task of determining which terminology to use in this thesis, that appears sufficiently value-neutral so as not to lead one down a particular heuristic route, mentally speaking, has felt insurmountable. Terminology is, by its nature, imprecise, and – as I've found – a matter of personal preference. It is, of course, not possible to reflect the whole range of preferences here, and so for the sake of consistency, I've chosen to use 'mental ill health' as opposed to 'psychiatric disorder', 'mental health condition', or 'mental illness(es)'. Whilst I take no issue with any of the latter options personally, many of the experts by experience whose anecdotes and reflections I draw upon challenge the notion of mental ill health or indeed psychiatry, as being a cause for medical concern. Whilst I attempt to remain neutral in those debates, and discuss mental ill health as a specific sub-type of medical or health related research; it would not feel fair to use pathologising terminology, and so I do not. The exception to this is where I use direct quotations from other scholars.

Similarly, ‘expert by experience’, which I have chosen not to abbreviate, is a phrase often substituted for ‘lay expertise’, or ‘expertise derived from experience’. At times I use the term ‘lay expertise’ to draw a distinction between non-medically trained ‘experts’ and those with traditional medical or academic training. However, I attempt to refer to the individuals who take part in coproduction, and are deemed qualified to do so based on their experiences of mental ill health, as ‘experts by experience’. Chapter Two discusses this concept further as a distinct ‘type’ of expertise.

And finally, I do make a number of background assumptions which underlie the arguments here. Firstly, I assume the reader has a basic grounding in debates in philosophy of medicine and psychiatry surrounding mental ill health, and particularly is aware that there is often dissensus or disagreement between clinicians and their patients. There is also a wealth of research which illustrates that who one is, in a demographic characteristic sense, can manifestly increase or decrease the sorts of biases that I will discuss. I assume that most of us are aware, again, at least in a loose sense, of the systemic racism, misogyny, and Anglocentricism that often underpin medicine, and by extension, psychiatry, in the UK. Save for a few instances where intersectionality is especially relevant to the points I make, however, I attempt to retain focus on mental ill health as the primary source of bias which is deployed in ways which minimise the credence or power assigned to testimonies of those with experience of mental ill health. This is not to say I do not believe that one’s ethnicity, gender, sex, or level of affluence will not afford privilege or compound the biases one faces, for I absolutely have reason to believe this will be the case. However, a discussion of how identity – real or presumed – can affect bias *within or in addition to* bias one faces as a result of mental ill health could be an entire research project of its own. Thus, to avoid giving short shrift to important debates, I touch on the notion of intersectionality only very briefly.

Lastly, I conceive of this work as a thesis which insofar as is possible, avoids making judgement about diagnostic categories, psychiatric treatment, or the legitimacy of psychiatric medicine. In Chapter 5 where I raise tensions in relation to these topics, I aim to give both sides of the debates equal weight. This however should not be taken as an indication of any particular psychiatry-critical view on my own part.

Thesis structure and chapter summaries

This thesis is split into three 'parts', each with a different purpose, and set of questions which the chapters within the thesis section work to answer. Part One, broadly, asks whether there is an epistemic injustice in coproduction. To answer this question, I argue in relation to three distinct questions:

(1) Where is the harm in coproduction?
(2) What is the role of knowing in assessments of epistemic (in)justice? And;
(3) Can patients possess expertise?

As I will demonstrate in Chapter One, discussions of coproduction, particularly in relation to mental ill health, often highlight that room has not been made for patient voice. This, patients report, is particularly jarring given that they have been given a seat at the metaphorical table.

As a brief insight into what follows, I will demonstrate, drawing on patient voices, the ways in which narratives from those with lived experience with mental ill-health demonstrate that participating in coproduced research has felt futile, or harmful (Rose and Kalathil, 2019; Näslund et al. 2018, Jones and Pietila, 2020). This, I'll argue, may constitute an epistemic injustice. However, I'll say that this should only be considered as such if we can demonstrate that patients know something that clinicians or academics do not (satisfying what Byskov, 2020, calls the 'epistemic' condition for epistemic injustice). Otherwise, drawing on work in the field of epistemic virtue, I'll argue that clinicians may be prudent to dismiss the testimony that those with lived experience give. The question, I'll then conclude Chapter One by posing, is one of whether patients can have expertise.

Whether patients can indeed possess such expertise is the question that Chapter Two seeks to answer. Setting out a range of ways in which we might attempt to understand 'expertise by experience', I consider 'traditional' accounts of expertise (Goldman, 2016; Watson, 2016) before drawing out a point in Goldman's work (2016) to show that knowledge derived from experience may well provide one access to information that one could not otherwise have. Discussing this then in the context of patient expertise, drawing on discussions from Dumez and L'Espérance (2024), Castro et al (2018), Tyreman (2005) and Watson (2023), I argue for the plausibility of patient expertise, as a distinct kind of knowledge with respect to a specific domain. This patient expertise, I argue, ought to best be considered as specific knowledge that is not possessed equally by clinical and academic members of the research team.

I then briefly take stock of the arguments from the first two chapters, in a brief summary of Part One, arguing that as it is possible that experts by experience have knowledge that clinicians do not, they satisfy Byskov's epistemic condition. This, I'll say, means it may well be apt to consider the exclusion of expert by experience voice as an epistemic injustice.

Part Two then asks which theory of epistemic injustice might be best place to explain the harms which Part One has set out. Chapters Three and Four, seek to answer the following:

(4) Which theory of epistemic injustice is best placed to explain the sorts of cases I consider?
(5) Is there a way of explaining the epistemic injustice at a systemic level?

In Chapter Three, I consider notable accounts of epistemic injustice, and ask how far each appear to explain the phenomenon set out. Discussing the work of Fricker (2007) with respect to *testimonial injustice*, I argue that it could do perfectly well at explaining each and every instance of expert by experience dismissal, by appealing to negative stereotypes about mental ill health, but that it fails to get us to a systemic picture of the patterns of such injustices. Fricker's *hermeneutical injustice* I also consider here, though I find the applicability of this concept limited, insofar as it indicates a conceptual lack on the part of experts by experience which I fail to find sufficient evidence for when it comes to mental ill health. I also discuss the notions of *epistemic objectification*, drawing on Nussbaum's (2006) understanding of objectification, and on arguments from McGlynn, as well as *epistemic othering*, drawing on Pohlhaus' (2013) arguments that contributions are permitted by marginalised individuals only insofar as they confirm the perspectives of the dominant group. These views, I argue have more plausibility, and appear to track much of what is common in the cases I consider. However, they are limited in their ability to capture all relevant facets of the ways experts by experience are treated, I argue. Lastly, I consider Anderson's (2017) work on *hermeneutical impasses*, and Dotson's (2012) account of *contributory injustice*, arguing that both of these accounts too, track intuitions about what goes awry in coproduction. I find that contributory injustice has the broadest applicability, but would require extension in order to fully capture the harm in coproduction. I conclude this chapter, however, by highlighting that any one of these accounts would explain adequately some elements of the central picture.

Chapter Four, however, discusses at length Dotson's (2016) *epistemic oppression*, and argues that this is a means of making sense of the harm in cases of coproduction which is able to explain the totality of the wrongful, harmful, and knowledge-limiting ways in which experts by experience are thwarted in their attempts to contribute knowledge to common understanding where that knowledge is contrary to commonly accepted views. Discussing Taylor's (2004) conception of the social imaginary, and Medina's (2011, 2012, 2013) concepts of *meta blindness*, *active ignorance*, and *epistemic friction*, I note a proclivity for maintenance of the status quo, insofar as norms of research, and of intellectual practice, privilege academic and clinically derived knowledge, and shut-down competing views. All of this, I use Dotson's account to say, means that our epistemological systems, as the governing 'frameworks' which contain our shared conceptual resources, and our habits and epistemic lifeways, can absorb, or explain away information that experts by experience give. Knowledge that they contribute which would challenge, or threaten accepted views is explained away, or pathologised. The position of experts by experience as individuals lacking epistemic power, who are more prone to credibility deficits, I say, is central to their inability to have their voices heard. I end Chapter Four with a problem case, relating to the applicability of epistemic oppression as I have presented the framework: it could apply in almost any circumstance whereby experts by experience feel their experience has been negative. This problem, I note, is not an easily resolved one, though I seek to set out some of the tensions which preclude being able to answer the challenge in Part Three.

Chapter Five, the only Chapter within Part Three, then asks how we might determine when the exclusion of expert by experience voice should rightly be considered an epistemic oppression, versus when excluding views which critique or are fundamentally opposed to psychiatric medicine in any form, may be the right thing to do. I set out a number of tensions one would need to resolve in order to be able to answer such questions, drawing on the work of Mad Studies, anti-psychiatry, and critical-psychiatry scholars, to show that within mental ill health, much is contested. I discuss tensions that arise in relation to diagnosis, treatment, and the concept of recovery, highlighting how our epistemological system could not contain the polarity of attitudes I set out and still continue to function coherently. This, then, helpfully demonstrates further the applicability of Dotson's view. It does not, however, help us to answer the question the Chapter explores. In fact, I argue that it is not practicable to give such an explanation, but that what we might take from the tensions that I explore, is that coproduction is *not* always the gold-standard approach to research that we should take. I end Chapter Five by sketching how values-based medicine and shared-decision making, might be better alternatives. This does not, I argue, deflate or diminish the utility of Dotson's view as applied here, because principally, my purpose is to give a systemic account of the inability of experts by experience to shape research direction as an epistemic harm: irrespective of where you stand on the tensions I outline, it becomes strikingly clear that there is no room for a holistic picture on all matters within our epistemologies.

Part One – A Seat at the Table: Coproduction, knowledge and expertise

---

Chapter One: Coproduction, mental health and the promise of parity – a recipe for epistemic harm?

1- Introduction

Epistemic injustice is far from being a new or novel concept. In fact, since the publication of Miranda Fricker's *locus classicus* 'Epistemic Injustice: Power and the Ethics of Knowing' (2007) there has been an ever-increasing interest in the subject. As such, you would be forgiven for thinking that there remains little left to contribute to social epistemology on the subject. In this chapter, though, and in this thesis more broadly, I'm interested in an extremely narrowly focused exploration of epistemic injustice. Here, drawing on the wealth of debate in social epistemology thus far, I'm interested in whether epistemic injustice allows us to make sense of what happens when coproduction goes wrong. Specifically, I'm interested in whether epistemic injustice allows us to explain a harm experienced by individuals with lived experience of mental ill health, in situations where they have been promised (explicitly or otherwise) parity of credence.

Coproduction is about, and in the realm of, knowledge production. As an approach to conducting research, it is lauded as the gold-standard for advancing what we know about a particular topic, in ways which increase the acceptability of our findings. In section 2, I briefly discuss what coproduction *is*. As my discussions will illustrate, what exactly the methodology entails can be difficult to pin-down. This may, in part, give rise to some of the harmful practice I'll then go on to discuss. In section 3, I then illustrate the sorts of cases upon which this thesis purports to go on to explain. In the cases I am interested in, individuals with lived experience of mental ill health, who have been invited to join a research team on the very basis of that experience, find that they cannot have their testimony ‘count’ in the appropriate ways. As we’ll see, this, at times, takes the form of being ignored, though at others, involves having the experiences relayed to the clinical or academic research partners pathologised, undermined, or even explained away.

Whether this *is* an epistemic harm, though, I’ll begin to argue in section 4, largely depends on whether we take it that we ought to believe such ‘lay experts.’ Typically, discussions of epistemic injustice skip, in my mind, a step of great importance: the question of ‘*should* we believe the person whose testimony we undermine?’ I’ll argue that, as the traditional gatekeepers of knowledge, academics and clinicians have a kind of duty to ensure that research findings are reflective of truth, or otherwise justified belief, on the basis of evidence. If, then, ‘lay experts’ are not contributing views which they can justifiably lay claim to, or, if *prima facie* it is not possible that one’s experiences can give rise to a particular kind of knowledge, then it is quite possible that the academic and clinical experts should *not* believe their testimony. I’ll end this chapter without having answered this normative question, but by having set the scene for what follows.

The questions this chapter focuses on, then, are relatively simple: first, is there a harm in coproduction? And second, what is the role of knowing in assessments of epistemic (in)justice? I argue in section 5 that concluding that those with lived experience ‘know’ might not suffice to justify their views being heard, because there are degrees of knowing. Such a resolution can only come then, from exploring the concept of expertise and how it might apply to patients. And whether patients can possess expertise that clinicians cannot (ordinarily) is a question that this chapter leaves open.[2]

2 – Motivating coproduction

Typically, in medicine – psychiatric or otherwise – there is a power asymmetry between clinician and patient.[3] And this power asymmetry is perhaps never more pronounced than in the realm of mental ill health, as the ability for clinicians to detain and treat patients, against their will, should there be sufficient concern regarding their safety, remains protected by *The Mental Health Act* (1983). In clinical settings, then, even where a positive relationship exists between patient and healthcare professional, it is – necessarily, some would argue – imbalanced in terms of power. And, we might think, and as I'll go on to discuss later in this chapter, that is how it ought to be. Doctors have completed medical training, and in most all cases, patients have not. In fact, we tend to seek out the expertise and skill of medical professionals when we ourselves have exhausted our knowledge or ability to manage our own health without medical intervention. Research, though, is not health*care*[4] but is an attempt to further our understandings of a particular topic. There are a great many ways in which one could undertake research, which range from desk-based systematic reviews, to randomised controlled trials (RCTs) which can recruit thousands of patient participants to test the efficacy, safety, or utility of a particular intervention. And many of these methodologies can be undertaken by an entirely academically qualified team. Coproduction, in that sense, is an anomaly.

---

[2] Such discussion is the focus of chapter 2 of this thesis.

[3] This power asymmetry is much discussed, and so I do not further argue that one exists here. For both early, and more recent discussions of such asymmetrical power, control and influence in clinical settings though, see for instance: Parsons (1951), Lee and Lin (2010), Heath (1992), Perakyla (2006) and Pilnick and Dingwall (2011).

[4] Though it may of course be about healthcare.

Exposition here is not intended to provide a complete checklist of what coproduction is, as, as we'll see, the concept is largely undefined. However, to understand what follows, and to see why what goes wrong in coproduction is so problematic, it is important to understand the key underlying features of coproduction.

At its core, then, coproduction requires the involvement of members of the public – often referred to as 'lay experts', or 'experts-by-experience' – as co-researchers. And, perhaps surprisingly, it has its origins not in health, or even in a field closely related to health, but in town planning. It has been described, in relation to public service distribution as:

> "the joint working of people who are not in the same organisation to produce goods or services"
>
> (Oliver, Kothari and Mays 2019)[5]

Here, though, we're not focusing on the apportioning of public service budgets, or on plans for a new building, but on health. And health is contentious. Patients often want different things, or have different goals when it comes to their own health to their doctors, and might also have strikingly different and individualised attitudes to particular health conditions or ills. Research findings in health can suggest ways of treating a condition which require strict adherence to a treatment plan on the part of patients, or can find that it is the patient's other behaviours which are exacerbating a condition. This was the case with smoking, and the link between smoking and incidence of lung cancer and other respiratory issues once proven, showed that patients who smoke, adversely affect their own health. Acceptability of research, then, particularly where there may be some change required in the patient population, must be paramount, if research findings are able to yield or catalyse changes in our approaches to health. And, coproduction has also been posited as having an overall

---

[5] On this, see also: Ostrom (1996) and Iedema and Carroll (2011).

effect of increasing the palatability of research findings, by being seen to democratise knowledge (Oliver, Kathari, and Mays, 2019: p.2). Sherry Arnstein (1969) noted that often, involving those whom decisions about apportioning of available resources would affect, improve the acceptance of subsequently made decisions amongst the community. This has given rise to a belief that coproduction, done correctly, can have impacts which are:

> "transformative not solely in research terms but in social terms: the engagement of citizens and social groups nourishes the renewal of democracy".
>
> (Flinders, et.al, 2016, p.26)

And, arguments have since been given, of direct relevance to this thesis, that this citizen engagement can introduce perspectives which can enhance planning, or research, if the range of voices included are sufficiently diverse[6]. Edgar Cahn (2002) for instance, writing about coproduction in corporate economics, implored governments and corporations to include individuals who are typically minoritised or subjugated in their discussions, demonstrating that participation in such discussions of individuals from all sections of society enhanced the ability of policy-makers to understand the lives and views that their decisions would encroach upon (Cahn, 2002). Cahn argued that in involving such a wide range of individuals, recognising the insights that their views yielded into the world, which he argued were unique in their perspectives, societal change in the direction of equity could happen (Cahn, 2002).

This involvement of non-traditional members of a committee, planning team, or research team then, represents a move away from technocratic approaches to knowledge (Oliver, Kothari and Mays, 2019) whereby norms and hierarchies of power and control are favoured.

---

[6] Giving patients a voice may well make them feel part of the arrived at solution. This could be true in a range of contexts, but I expect will be particularly true where research findings are contentious, or indicate some culpability on the part of the patients.

Coproduction is viewed often as a more democratic way of working where a wider range voices have a place. This, though, requires that particular importance is placed upon involving the right people, in the right ways. If done successfully, coproduction might present an opportunity to mend relations between traditionally ‘hostile’ users of a service and those to whom such hostility may be directed at (Oliver, Kathari and Mays, 2019; Walter et. al, 2003).

Perhaps then, the histories of tension between users of mental health services, and the institution of psychiatry, render it unsurprising that coproduction has become a popular, and much-discussed methodological approach to research in relation to mental ill health.[7] The bringing together of both clinician and ‘patient’ voice, and the diversity of views which such union engenders, could provide a more holistic range of perspectives which might enhance the research picture that emerges from the course of any project. As Coulter and Ellins (2006) explain:

> “the clinician has knowledge of diagnosis, treatment options and preferences, aetiology and prognosis, and the client [patient] knows about the experience of illness, social circumstances, and attitudes to risk, values and personal preferences”.
>
> (Coulter and Ellins, 2006 – discussed in Realpe and Wallace, 2010).

The multi-dimensionality of knowledge that can be amassed when one coproduces research, then, and the value of those diverging perspectives and understandings, as Cahn (2002) discussed, are motivations which are baked into coproduction at its very core.

---

[7] A full and proper discussion of such histories is, regrettably, beyond the scope of this thesis. See, however, for instance: Szasz (1974) presents a renowned critique of the power of psychiatry, as does Foucault (1988). For a more contemporary discussion of the anti-psychiatry movement, and the claim that mental ill health is not an illness, but a way of being, see also Rashed (2019).

2.1- Sharing of power and control

There are a great many ways in which one might involve patients in health research, however. Coproduction is but one of a whole series of involvement and engagement activities that would include lay experts, or members of the public in one's intellectual endeavours. Collaborative research practices, a requirement of much grant funding (at least in the United Kingdom)[8] vary in the degree of involvement required of members of the public. Such involvement can range from mere consultation, or stakeholder engagement, through to knowledge translation, co-design, co-creation, and coproduction (Oliver, Kothari, and Mays, 2019; Fransman, 2016). And recognition of the degrees of involvement that can be undertaken, has its roots in Arnstein's original '*Ladder of Citizen Participation'* (2019). Arnstein depicts involvement as a hierarchy, or ladder, whereby each 'rung' requires progressively more of the 'experts' in terms of the depth and degree of their engagement with the public (1969: 25). And, whilst she recognises that those in positions of greater power, and those who do not have such power, do not represent "homogenous blocs" (2019: 25), she acknowledges that typically, the latter group are the ones to whom opportunities to take part are extended; the traditional researchers or policy teams are the *de facto* controllers of any engagement process (Arnstein, 2019). In Arnstein's typology, coproduction is not mentioned by name, though 'partnership', 'delegated power', and 'citizen control', as approaches to research are all discussed as 'rungs' which afford ever greater degrees of control to the members of the public (Arnstein, 2019: 30-33). I raise this

---

[8] The UK Research and Innovation funding council (UKRI) for instance, have a webpage acknowledging the importance of public involvement in a range of different research types: https://www.ukri.org/what-we-do/public-engagement/how-ukri-supports-public-involvement-in-research-and-innovation/#:~:text=We%20know%20that%20public%20involvement,research%20is%20acceptable%20to%20people. The National Institute for Health and Care Research also require that public involvement is a component of research funding proposals, see, for example: https://www.nihr.ac.uk/career-development/health-and-care-research-introduction/involve-patients.

point in particular, as depending upon one's view, any one of these 'rungs' could be typified as an instance of coproduction – as this section will demonstrate, there is no precise explication of what exactly the methodology is, or requires. What is ubiquitous in discussions about what coproduction is, or could be, however, is an emphasis upon power sharing. This, as Alba Realpe and Louise Wallace (2010) note, should be:

> "based on the sharing of information and on shared decision making between the service users and the providers. It builds on the assumption that both parties have a central role to play *in the process* as they each contribute different and essential knowledge"."
>
> (Alba and Wallace, 2010; emphasis added)

Inconsistency throughout the process, then, or involvement which might be considered tokenistic, should be an indication that the methodology or approach to public involvement being undertaken is not, in fact, coproduction (Cummins and Miller, 2007). Tokenism, levelled as a criticism at many well-intentioned but poorly executed initiatives, may, I suspect, be more pronounced in circumstances whereby there is little trust or goodwill between parties. Trust, as Tony Bovaird explains, is a pre-requisite for successful working together:

> "Coproduction means that service users and professionals must develop mutual relationships in which both parties take risks—the service user has to trust professional advice and support, but the professional has to be prepared to trust the decisions and behaviours of service users and the communities in which they live rather than dictate them."
>
> (Bovaird, 2007: 856)

The trust that the professionals need to place in the lay experts with whom they partner, is no small feat. As the beginning of this chapter noted, oftentimes, clinicians and academic are treated as *the* authority on matters of psychiatric health, and thus relinquishing some of that control, and demonstrating a willingness to recognise the value of experience, and capacity for decision making is surely no small feat.[9] In fact, as we'll see in what follows, I will argue that it is dubitable that such sharing of power is practicable outside of theory. Discussions of challenges in undertaking coproduction have demonstrated:

> "the application of co-productive and emancipatory research principles demands that power and control dynamics between those traditionally situated as 'patient' and 'clinician' must be fundamentally addressed in research practice"
>
> (Lambert and Carr, 2018: 1274).

What I take this to mean is that, contra to stakeholder engagement, whereby individuals with lived experience of mental ill health might be consulted, though by no means considered an equal partner, is that coproduction demands of its participants a flattening of existent hierarchies. Though what I'll say in what follows casts doubt upon the tenability of such levelled dynamics, it is not hard to understand why co-working requires such a shift. Only by allowing for the possibility that lived experience can potentially make one an "expert in their own circumstance" (Boyle, et. al, 2006) and as capable and trustworthy testifiers about the knowledge amassed from such experiences can we infer that the power and control to co-create knowledge are indeed shared. To what degree, and in which particular contexts of the research project it is appropriate to completely share power, as I'll discuss in later Chapters, may be a matter of debate and discussion. A central tenet of coproduction, though, is the need for researchers to partner, in equal terms, with those who are typically research*ed*.[10]

---

[9] Though should it be achieved, the potential, in emancipatory research terms, is Slay and Stephen's (2013) claim, 'transformative'.

[10] Clark (2015) and Needham and Carr (2009) both discuss the differing ways in which the term 'coproduction' is used, with the latter authors referring to it as an 'elastic concept'. The sharing of power and control, though, are central in these and many other discussions of what coproduction might be.

3 – Anything but equal: undermining patient contributions

Such partnering, however uncontentious it may seem in theory, is fraught with difficulty. In this section, I will explore a range of anecdotal accounts of the ways in which patient testimony has been treated; or perhaps better, censored, which are presented in the literature surrounding experiences of coproduction. With the caveat that I am not arguing that coproduction requires equal credence in each and every step of the research process,[11] where it is appropriate to have those with lay experience involved, we might assume that their testimony should be treated with equal regard to their academic/clinical counterparts. For instance, in a working group discussion, it might seem appropriate to include lay experts, and to have them coproduce the agenda, the topics of focus, and to have the equal capacity to contribute to the ensuing discussion. This ought to include being able to have explanations, hypotheses or reflections treated as viable topics worthy of further exploration. In reality, what is often remarked upon by those with lived experience of mental ill health is quite the opposite.

3.1 – Reflections on coproduction

In section 2.1. I touched upon the notion of tokenisation. This, I understand as being involvement for the sake of lip-service or the appearance of having made a commitment to include individuals with lived experience, without demonstrable evidence of the giving over of power or control to those individuals. And reflections of involvement in research heavily

---

[11] Some would disagree with this claim, disputing that public involvement (to any degree) cannot be undertaken where convenient, and not where the converse is true, however as I'll go on to say in relation to expertise and belief in a speaker, there are certain aspects of the research process which we possibly would not *want* non-clinical or non-academic members of the research team to have equal control over. This does not entail that control could not be shared equally over the project on the whole, but that for medicalised, or especially technical matters, power asymmetries may be *required* such that research remains safe and ethical.

feature or make reference to feeling as though one's participation was demonstrative, or tokenistic, as opposed to meaningful and change-making. This is particularly true of individuals whose own experience, or diagnosis, is that which is being discussed by the academic/clinical research team members. As Jayasree Kalathil (2019) recounts, she:

> "was one of the only two people who had the lived experience of being diagnosed with mental disorders and subjected to psychiatric interventions in the whole group. This immediately raises issues of power and the possibility of speech. I was being asked to speak about my personal experience alongside others who wrote about people like me as deranged human beings, with a corrupt mortality and a disordered personality. These others contributed routinely to the very knowledge base that makes it possible for one group of people not only to pass medical and moral judgements on another group of people, but also to claim the possession of a "correct morality" to fix them. What possible effect would my little story of being diagnosed with personality disorder have, faced with centuries of collective professional wisdom on the subject… In the end, after discussing the issue with the organizers, it was clear that I had two realistic options: one, accept the context and its inherent hierarchies and continue to collaborate within the apparently immovable constrains of its parameters, or two, refuse to engage, both options essentially making my knowledge "unspeakable". I chose the latter."
>
> (Rose and Kalathil, 2019: 3)[12]

What Kalathil expresses here, is similar to 'epistemic imperialism' which Iris Marion Young (1990) discuss. Central to the notion of epistemic imperialism is a pressure that individuals (typically from marginalised communities) conform to dominant groups' understanding of a topic, having that same understanding imposed upon one's experiences by the dominant

---

[12] The ellipsis in this quotation represents a fairly significant chunk of reflection which I have chosen to omit here, as it introduces Kalathil's experiences as a woman of colour, and the ways in which being a member of a minoritised ethnic group further compounded her feeling unable to have her voice count. This is in no way a reflection that Kalathil's experience as a woman of colour is not important, or relevant. However, as I noted in my introduction, it is not possible to discuss intersectionality in a way which avoids paying short shrift to points of incredible importance. As such, I have made the choice to keep the discussion focused upon the experience of having had a mental ill health diagnosis. You may be unpersuaded that it is possible to disentangle these facets of identity, and I am sympathetic to that view. It also strikes me as so obvious as to not need saying that privilege (as with disadvantage) will depend on race, class, education, sex and gender, and where one is minoritised in more than one area, the barriers one encounters in being taken seriously will of course be compounded. As we'll see in this thesis, though, there is plenty to discuss focusing on mental ill health alone. For further discussion of racialised bias in mental health care see, for example: De Maynard (2005); Faber, et. al (2023); Fernando (2019), and Thompson and Neville (1999). Faissner et. al, (2024) also begin to explore intersectionality and discrimination in mental health care.

group (Wieseler, 2020; Young, 1990). If Kalathil had taken the first of the options she explains as having been available to her, this would be akin to continuing to share her experiences whilst cognisant that the dominant group (the clinicians present in the room) would interpret her testimony through a traditional psychiatric lens. This could have, though there is of course no means of confirming this suspicion, involved some element of continued pathologisation of her experiences – personality disorder diagnoses remain amongst the most damaging, reputationally, to the individuals who have them, with even some clinicians expressing a preference to not work with patients with that cluster of diagnoses (Lewis, 1988; Chartonas, 2017).

What I believe Kalathil also gestures to here, is feeling as though there is a requirement to 'sanitise' one's perspective, to make it acceptable to the dominant group in the room.[13] The need to speak in ways which are acceptable is also demonstrated in Marjaana Jones and Ilkka Pietila's (2020) review of the experiences of individuals undertaking specialised training to become eligible to take part in patient and public involvement activities.[14] In order to 'pass' the training program and be cleared to take part in research, the Finnish participants had to demonstrate a suitable degree of recovery and to evidence stability in their psychiatric health. This is not necessarily a negative, as it presumably comprises an element of ethical safeguarding of the psychological safety of lay experts. However, some participants understood this requirement as being indicative of an exclusion of those "who lack hope and motivation" (Jones and Pietila, 2020: 816). This may be taken to indicate that the voices of

---

[13] 'Sanitise' I understand here as a need to 'make sane' one's testimony. I take this to indicate the need to remove emotion, to censor one's views perhaps, and to potentially even avoid asserting views that one knows have been previously pathologised.

[14] The authors' paper focuses on the experiences of Finnish 'experts by experience' undertaking a training program which seeks to equip participants with the right kinds of storytelling skill to be able to usefully contribute in research spaces. To my knowledge, such training programmes are not widely available, much less required, in the UK or in North America.

those who could never imagine life returning to pre-mental ill health standards could be ruled out, particularly if a hopelessness were expressed (Frank, 1995: 97). In essence, what Jones and Pietila found, was that only those individuals who had learned to “structure and present their experiences in ways that health professionals and health services find acceptable and relatable” (2020: 820) were likely to pass the program, and be qualified to undertake public involvement activity. Näslund and colleagues (2019) note similarly that the experiences of those with mental ill health conditions need to be relayed “in a manner which shows that the narrator is in control of their story and emotions” (Näslund, et. al, 2019). Failure to demonstrate such self-control, or mastery of one’s emotions and the recovery journey may mean that lay expert’s testimony is received as “incoherent or difficult to understand… [in ways that make it probable it] may not be regarded as “fit for purpose”” (Jones and Pietila, 2020: 820).

A further feature of Kalathil’s recollection was the futility of recounting her own story when it was unlikely to be heard. However, being heard is not the end of the issues encountered by those with lived experience, as Jasna Russo discusses in her ‘*In Dialogue with Conventional Narrative Research in Psychiatry and Mental Health*’ (2016). Russo argues that whether lay experience is presented in the form of a story, or as a set of interview responses, those deemed ‘Mad’ by the traditional experts are treated primarily as data sources, not as individuals (2016: 216).[15] Russo goes on to explain that her own experiences

---

[15] ‘Mad’ is claimed, by some with lived experience of mental ill health as an identity, as opposed to a subjugating label. In much the same way as ‘queer’ has been reclaimed by members of the LGBTQ+ community, ‘Mad’ as an identity signifies both a demand to be accepted societally without need for change, and assumes a particular stance with respect to the medicalisation of mental ill health. Rashed’s (2019) *Madness and the demand for recognition* provides an excellent discussion of both the claims made by community members who use the term, and the histories of ‘Madness’. Whether reclamation of subjugating terms can ever be a success, I leave open. However, where ‘Mad’ is used by those with lived experience to signify their position on mental ill health, I do not remove it.

in coproduction have been ones where she has been ”*interpreted* instead of heard” (2016: 216). Further, she claims elsewhere, that such interpretation can render the knowledge offered by a lay expert so changed it becomes almost ‘alien’ (Russo and Beresford, 2015) and claims that:

> “we often find ourselves giving not just our story but the also the knowledge that has emerged from our experiences only to have it reframed, serving various purposes and different agendas, and ultimately alienated from us”
>
> (Russo and Beresford, 2015: 153).[16]

And, of course, interpretation is an exercise in meaning-making, however, the power imbalances I outlined in section two mean that lay expert testimony is often altered in significant ways. As Russo says:

> “By assigning the tasks of understanding and making means of madness to ‘experts’ and not to those directly concerned, the great majority of narrative analyses perpetuate the role and power divisions central to psychiatric treatment”
>
> (Russo, 2016: 216).

What is striking is that such a power division is precisely what coproduction was intended to redress. And so, the fact that individuals participating in coproduced projects, who have experiences of the psychiatric system, and in fact have been invited to co-lead research on the very basis of that experience, feel the need to make acceptable their testimonies, detaching them from any personal emotion to avoid having them treated as data points rather than valid points capable of directing further inquiry, casts doubt upon the flattened hierarchies that coproduction promises. This, some argue, is not a cause for surprise. It is, however, concerning. As Jasna Russo and Peter Beresford (2015), discuss:

> “We ask ourselves why approaches that first seem inviting and like they might even help to disrupt psychiatric control over our voices, ultimately resort to marginalising mad people’s own knowledge, and how this happens. This consistent marginalisation particularly applies to our collective knowledge, which rarely gets a place at the ready laid academic table”

---

[16] See also Costa et. al (2012).

(Russo and Beresford, 2015: 154).

In many ways, the question which Russo and Beresford pose here is that which this thesis seeks to answer.

The need to sanitise, or rather the felt need to sanitise one's testimony though, raises the question of how and where lived experience might factor into research domains, and one might also ask whether it should. Decoupling personal and emotive life experience from an experiential account is something that a number of authors argue is not even *prima facie* possible (Jones, 2005; Smythe and Murray, 2000). Much less, Smythe and Murray argue, ought this detached way of recanting one's experience be a requirement for knowledge presented in the form of a narrative account (2000). For, if the attraction of coproduction as a potentially transformative research methodology has any grounding in reality at all, it is surely those personal stories, which Coulter and Ellis (2006) noted above, which motivate the involvement of lay experts in the first instance. David Crepaz-Keay (2017), discussing Russo's 2016 work that I reference above, argues that:

> "the forceful denial of our role in knowledge production, or, even, as legitimate knowers certainly calls into question the possibility of coproducing knowledge"
> (Crepaz-Keay, 2017: 316).

And such scepticism is not difficult to understand, particularly when one considers that the promise of being an equal partner was nothing more than being paid lip-service to. As another lay expert recalls:

> "I wanted to study peer support and patient involvement in psychiatric services through action-research method. They also agreed that I would collect ethnographic data on the research group's activities as part of my thesis. For a while, the clinic's leaders had been saying that they needed a plan to 'engage service users'. I told them

> I could help them figure that one out. They said good, come on in. Through repeated frustrations, I progressively realised that the clinic's interest in user engagement was essentially tokenistic: the doctors running the clinic wanted to co-opt a few 'service users' to give outsiders the impression that the clinic valued 'lived experience' and 'co-constructed' service improvements with patients, trendy terms nowadays. In reality, however, their 'engagement' efforts were set up and managed to prevent patients from gaining a genuine voice or from influencing established research and clinical practices".
>
> (Bouchard, 2019: 3-4).

Understandably, having experiences such as these has at times provoked anger in the lay experts who feel as though they have been at least misled, and perhaps at worst, harmed, by being invited to co-create knowledge, only to find that promise hollow. Such anger, though, has too been pathologised (Sen and Sexton, 2016). By this I mean that outbursts, or the expressing of displeasure in emotion-filled ways can, as Rose and Kalathil (2019) note, be understood as manifestations of one's psychiatric instability or illness. This seems unfair, as I think it safe to say that most of us would be displeased, and may voice our dissatisfaction if having given up our time, and invested emotionally in retelling our own stories of distress, we found that our views were not valued at all.[17] However, having a diagnosis of a mental ill health condition can affect the seriousness with which our affective states, and indeed testimony unrelated to our mental health is received, as Sanati and Kyratsous (2015) note. Often, and as I'll discuss in much more depth as this thesis progresses, having had a diagnosis of a mental ill health condition can suffice to cast doubt upon the reliability of *all* of one's testimony, irrespective of whether that testimony actually relates to your experiences of mental ill health.[18]

---

[17] Such pathologising of righteous anger or annoyance, could even be understood as *epistemic violence* as discussed by Maria Liegghio (2013). Liegghio describes such violence as "institutional processes and practices committed against persons or groups… that deny their worldviews, knowledge, and ways of knowing, and consequently, efface their ways of being" (2013: 123). I return to a discussion of Liegghio's work in chapter 3.

[18] The actual claims made by Sanati and Kyratsous in relation to the particular case they consider have been challenged as making an assumption that truth is the only goal of clinical encounter (see for example, Harcourt

3.2 – Where does this leave coproduction?

Those with lived experience of mental ill health, then, appear to face something of a double-bind, if we accept that their experiences have been negative in the ways outlined in 3.1. To be involved in coproduced research, individuals must ordinarily – though it is important to note, not always – have a personal acquaintance with, or experience of, mental ill health. And yet, it appears that their participation comes with conditions which are not laid bare, with respect to the detached manner in which they must relay deeply personal experiences. Further, such experiences may be received as information upon which clinical interpretation is then carried out. If individuals manage to avoid having their views dismissed or skewed in the face of such clinical interpretation, they may still find that their original diagnoses (and the very reason they are taking part) are then used to cast aspersions about the reliability of their testimony, or the validity or objectiveness of their claims. The role of objectivity I discuss in much more depth in Chapters 3 and 4. The aspersions that individuals may find cast on their views though, can have the result of appearing to justify doubt with respect to their understanding, making their testimony unbelievable. In many cases then, having a mental ill health condition appears to simultaneously make one eligible to take a seat at the metaphorical research table and risk rendering one's voice silent.

This, I hope, demonstrates why there has been a sense of disillusionment amongst lay experts with respect to the merit of coproduction. Meaning-making as an exercise which seems to subvert what one wanted to convey, is argued as being tantamount to

---

(2021). However, their broader point here is well evidenced in other sources (for example Crichton et. al, 2017; Lakeman, 2010).

"marginalising mad people's knowledge" (Russo and Beresford, 2014: 153). This, in some respects, gives rise to a tendency to jump straight to the claim that there are concerns about the credibility of those with mental ill health which give rise to such negative experiences.[19] And such a leap would be easily understood: folk conceptions of mental ill health are negatively correlated with features we associate with being a credible individual. Mental ill health has an extraordinarily long and enduring history of being associated with predilection to violence, volatility, and unreliability (Guidry-Grimes, 2015). In fact, central to the very understanding of mental ill health in society is a presumption of some thought disturbance, or irrationality (Angermeyer and Matschinger, 2005; Angermeyer and Dietrich, 2006). As Valentina Cardella remarks:

> "after all, mad people are mad because they are irrational, and madness is in the realm of nonsense, so irrationality is supposed to be a crucial part of madness"
> (Cardella, 2020: 17).

In the following section, I will begin to explore further this claim that the sorts of cases I've outlined here constitute a kind of epistemic injustice. For now, what the above indicates is that there is reason to suppose that having a mental ill health condition or diagnosis just does mean that, in some ways, you may encounter difficulty in being seen as a credible knower. Psychiatrists have not, historically, disputed this fact (Crichton et. al, 2017). For now, the relevance of these observations and findings lies in the beginnings of giving an explanation of what is happening in coproduction, and perhaps why this is the case. Or, better, by setting out what it is that I will go on to explain. What is apparent, however, is that

---

[19] By, for instance, claiming that these are all instances of epistemic injustice.

the need to co-locate power and influence among lay experts and the academic/clinical members of the research team is not without challenge (Porter, 1987; Beresford, 2009; Beresford et al, 2016; Carr, 2016). The notion of rationality undergirds empirical science, and the experiences outlined above which depict a need to almost make one's lived experience appear objective, and devoid of emotion, could be a result of our tendencies to consider science as necessarily 'value free'.[20] What counts as knowledge, and indeed *whose knowledge counts*, is not 'supposed' to be influenced by emotion or positionality.[21] Veridical and replicable research findings are supposed to be the aim of the science game, and emphasis on justification for belief often fails when appeals to others' testimony is the primary evidentiary source. One must robustly justify *why* the interlocutor whom gave us a particular piece of information is qualified to have done so. Given the tensions between mental ill health and rationality, reliability, and – for some authors – morality, that I touched upon above, it is perhaps not difficult to see the apparent tension that emerges between involving those with lived experience, and being able to take them as reliable sources of information, capable of guiding or shaping scientific inquiry.

4 – A place for lived experience?

We might, then, begin to wonder, is there a place for knowledge derived from lived experience at all? If objectivity is what's at stake, then perhaps Smythe and Murray's (2000) arguments that knowledge derived from experience simply cannot ever be presented in a

---

[20] This is not a settled claim, and recent work in the philosophy of psychiatry and in psychiatry more broadly has introduced the notion of values-based medicine. Whether any science is actually 'value free' I leave open, though there are numerous positions on either side of the debate. For recent discussions of this debate, see especially Brown (2024), Menon and Stegenga (2023), Resnik and Elliott (2019).

[21] Linda Martin Alcoff (2010) argues against this view, in her discussion of the now infamous speech of Justice Sotomayer's regarding the need for impartiality and value free reason.

manner decoupled from the subjective, or lived-, position from which it was amassed cast the possibility of coproduction in an altogether negative light. However, there have been examples of coproduction done well, albeit whilst acknowledging the over utilisation of it as a research methodology (Crawford, et. al, 2002; Mockford, et. al, 2012; Sharma, et. al, 2017; Harcourt and Crepaz-Keay, 2023). This, authors claim, is a result of uncritical evaluation of potential methodologies, and a blind assumption that more involvement is usually better. I'll argue that this likely is not true. Further, nothing I say here, or in the remainder of this thesis, will indicate that coproduction ought to be considered a panacea in mental health research; quite the contrary. But simply giving up on the notion of knowledge derived from experience as having a place in the scientific endeavour seems similarly misguided. As section two of this chapter set out, the benefits of collaborative research, including more democratised knowledge, and the possibility for research findings which represent the holistic nature of our embodied world, make coproduction something that in the *right* circumstances, we probably should want to explore.

To do so, we must find a place for lived experience. And, as section three has demonstrated, the path to carving out that place is far from simple. The practices, as outlined in this chapter, prevalent in coproduction, which do not appropriately carve out space for lay experts voice, have tended to be understand as harmful. As I have mentioned, this harm is ordinarily argued to be one which is epistemic in nature: *epistemic injustice*.[22] Epistemic injustices, as I will discuss at length in the following chapters, are understood as harms done *to* an individual in their "capacity as a knower" (Fricker, 2007: 17). This, ordinarily, is coupled with the notion of some ethical transgression on the part of the

---

[22] See, for example: Carel and Kidd (2014), Crichton et al (2017), CoProduction Collective, Kidd et. al (2022), Lakeman (2010).

individual, or group, who are responsible for assigning credibility deficits which lead to such undermining. The question of whether there is an epistemic injustice in the cases outlined in section 3 may even seem a ridiculous one to ask! It may strike us as an intuitive truth that there is a harm in the scenarios I have set out, or even indubitable that in some non-trivial sense, that harm is epistemic in nature. And yet, a step that I believe those who argue for the plainness of epistemic misconduct in these kinds of cases miss, is a question we rarely see asked: *should* we believe those with lived experience?

4.1- Revisiting Fricker – normative questions in epistemic (in)justice

On Miranda Fricker's (2007) account of *epistemic injustice*, there are two main features of the prejudice-based harm: (i) a negative identity prejudice is contained within a stereotype about a particular group; (ii) that stereotype – used as a heuristic aid in conversation – is used to deflate, or downgrade, an individual's credibility, such that they are disbelieved, or not taken to be a reliable source of information.[23] The classic example Fricker uses to elucidate this in practice, is that of Tom Robinson in *To Kill a Mockingbird*. There, racial prejudice contrasted with white privilege led to Robinson being disbelieved by a jury, because of the stereotypical preconceptions about Black men, and violence in 1930s America (2007: 24-27). And on its face, this seems an incredibly plausible and intuition-tracking view of how and why we (dis)believe our interlocutors. Faced with a wealth of information, in the moment, we must rely upon heuristics to allow us to gauge the relative likelihood that some individual, or other, is telling us the truth. Then, we must determine whether their account strikes us as sufficiently plausible, or whether they strike us as

---

[23] My discussion of Fricker here is brief, as an application of the mechanisms of *testimonial injustice* will be undertaken more fully in Chapter 3.

sufficiently credible, that we might accept their word and, where required, accordingly adjust our own belief-set. Of course, truth is not the goal of all interaction, and as such, it might not be the case that I determine someone unbelievable, or presume they are lying, but I may be attempting to further my knowledge of a topic where absolute truth would be hard to qualify. In these cases, my aim may be different: it could be to interpret, to understand, to assess, or to gauge the reasoning of another. My belief, and whether a stereotype underlies that belief, in my interlocutor's ability to credibly relay information to me, is what matters (Fricker, 2007: Ch.2). As such, epistemic injustice is a relatively simple theory, which I have no doubt has increased its attractiveness to those of us working in spaces where we attempt to make sense of the experiences of marginalised or subjugated communities. It is a widely used conceptual framework. This is true also in and of mental health. Philosophers have applied the concepts of epistemic injustice to all kinds of interaction in the health and mental health space, though predominantly in exploration of clinical encounters.[24]

Here, though, I want to pause for a moment. I have said a little, and in chapters to come I will say much more, about the negative societal stereotypes which surround mental ill health. Thus, appealing to negative stereotype in understanding the experiences of a community who undoubtedly do experience the harmful effects of that stereotype is understandable. But, to avoid paying short shrift to the folk-understandings of mental ill health, and indeed, to explore an avenue which has not much been explored to date in discussions of epistemic injustice, I want to ask a preliminary question that is normative in nature: *should* we believe lay experts? That is, in denying someone in their capacity as a

---

[24] In addition to those sources in fn.19 you might also see: Harcourt (2021), Kidd, et al (2023), Okoroji et al (2023), Russo (2023), Scrutton (2017), Sanati and Kyratsous (2015) and Wodzinski and Moskalewicz (2023).

knower, can we make a claim that lay experts, or experts-by-experience, do indeed know? This, I'll argue in what follows, is important, because if we cannot say that those with lived experience of mental ill health do indeed 'know' something, then whilst we may still deny their epistemic agency, we may not commit an *injustice* (Byskov, 2020: 116).[25] Further, is it possible that in some contexts, the lay experts know to a greater degree than their academic or clinical counterparts – that is, can they be said to possess expertise?

The remainder of this chapter is dedicated to providing an explication of why we should take seriously such questions. The following chapter (chapter 2) will then attempt to answer them.

4.2 – Knowledge and good epistemic practice

To argue that we may rightly apply the concept of epistemic injustice to the exclusion of lay experts' voices in shared attempts to coproduce knowledge, we then need to attempt to evidence that there is indeed knowledge, that we preclude such individuals from contributing to shared spaces. This preclusion comes in the form of our deflating their credibility (using Fricker's (2007) account) based on negative stereotypes upon which we rely, in the course of ordinary conversations.

In asking whether an individual with lived experience can indeed be presumed to 'know', it is important to be clear regarding what exactly is being asked. Ordinarily, a question regarding knowledge would be concerned with completing a statement of the form 'agent *S* knows that *p* iff…'. Here, my purpose is slightly different – I am not providing an account of

---

[25] This, I accept, could have ramifications for claims of epistemic injustice more broadly. Here, my focus is on determining whether the clinicians or academics are acting prudently to not take seriously those with lived experience. Whilst it may be that the discussions could be held in parallel with respect to epistemic injustice more broadly (and Byskov (2021) for instance does claim as such), I do not attempt such generalisation here and indeed it falls beyond the scope of this thesis to do so.

knowledge, nor justified true-belief in this thesis, but instead am concerned with a practical discussion of the above question.[26] The philosophical tradition of meta-epistemology however, has extensively engaged with the question of what comprises knowledge, and, indeed, what we are attempting to *do* in completing the schematic statement above.[27] What I do not seek to do here is to engage in a meaningful way with such meta-epistemological views, for to do so would be to likely overlook important arguments, or to mischaracterise the views available for one to engage with.

So, let me reframe. When I ask the question of 'does individual *S* with lived experience of mental ill health *know*…', I am asking whether they warrant credence with respect to testimony shared regarding their own experiences, understandings of those experiences, or awareness of their own particular mental states, at a given point in time. Further, is such credence warranted based on authority that we can place in them? Thus, the question is much vaguer, and my usage of 'know' far more colloquial than one which aims to determine whether *S* knows that *p*. In fact, I am sceptical that we might ever be able to give arguments which would provide us with a definitive answer to the more formal sort of question, in relation to the kinds of knowledge statements I've indicated that individuals with lived experience are likely to contribute. It is difficult to imagine what truth-conditions could possibly be assigned to a statement such as 'I felt really low' or 'being sectioned ruined my life'. Rather, clinical observation often takes the place of veridical inquiries in the form of laboratory tests, when it comes to mental ill health, due to the paucity of available objective

---

[26] In fact, such a discussion or account could easily comprise a thesis dedicated to the topic, and likely still leave many open questions.

[27] For an excellent overview, see for example Sosa (2015, 2021); Zagzebski (2020). According to the latter, knowledge gaining true belief as a result of intellectual virtue – a "deep and enduring acquired intellectual excellence consisting of an admirable intellectual motive disposition and reliable success in reaching the truth because of the behaviour to which that motive leads" (2020: 103).

means of confirming the ‘presence’ of a mental health condition.[28] Testimony, along with clinical observation, stand in place of “truth”, as the best we are able to do in most psychiatric contexts, is to work with the empirical knowledge available to us. As our purpose for exploring this question at all is one of determining whether we *should* believe an individual with lived experience, this makes providing an answer challenging.

When faced with testimony (which cannot be truth-verified in any real sense of truth), *t*, which introduces ‘knowledge’ into a shared discursive space – such as the research contexts I am examining – individuals typically, even in truth-absent circumstances, will typically assign either belief, or credence to *t*, such that they can determine whether and how to assimilate the views *t* contains into their own epistemologies.[29][30] Credence, can be understood as the probability or confidence that an individual or agent has with respect to a particular proposition; propositional content which contradicts views already held, if those views are well-justified, should result in a low credence being assigned to the new information, or, a reconsideration of that justification if one believes the new evidence to be particularly compelling. Should *t* not ‘fit’ alongside one’s other rationally formed epistemological commitments, then, as Christopher Hookway (2001) has argued, to be considered an *epistemically continent* agent, one would disbelieve *t* in the absence of clear, and good reason (2001: 195). There will, of course, be reasons that we might abandon previously held beliefs, for instance upon learning that they were things told to us as

---

[28] Harcourt (2021) discusses this as being the primary purpose of a clinical assessment, for instance.

[29] This immediately strikes one as being a particularly coherentist sort of statement. I am, however, not a dialetheist, and thus think that one ordinarily ought not to simultaneously believe *p* and not-*p*. This coherentism (lite) understanding of how our world view remains stable will be particularly important in chapter 4.

[30] There is disagreement amongst epistemologists with respect to whether both credence and belief, or one over another, are most important when it comes to knowledge and justification. See, for example: Staffel (2019), Buchak (2014), Jackson (2022) and Weisberg (2020).

children which have no grounding in reality. Such beliefs might have been useful tools for avoiding dangerous or irritating behaviour, that we did once have good reason to believe (our parents told us), but once we then discover better reason to disbelieve (we discover for ourselves), we should on balance do so. And such examples range from the trivial, as I have construed them, to the more serious – think political views, conspiracy theories, and the like. We can believe in things, and it can transpire later down the line that we were incorrect: epistemic agents are not infallible. What Hookway appears to be getting at though is prudence in our epistemic conduct, and consideration of evidence and justification for credence we assign. And the concept of *epistemic prudence* has been defined by Code as involving:

> "judging which lines of enquiry it is prudent or imprudent to pursue, having a sense of one's limitations, and being able to see the impossible difficulties certain lines of enquiry might bring about"
>
> (Code, 1987: 55).

Thus, epistemic prudence is, on Code's view, an epistemic virtue: something we ought to promote and do more of, or a signifier of a rational and well-reasoned individual.[31]

This is relevant to coproduction then, insofar as if there's no reason to suppose that the individual with lived experience has the authority to speak to the topic they opine on, and/or their testimony or presentation does not afford significant reason to reconsider my existing beliefs, it may well be prudent to disbelieve them, or to attempt to make sense of what they literally say based upon what I believe to be empirically supported. And there may well be reasons in which disbelief in an individual with lived experience's testimony is

---

[31] A virtue, perhaps, in our way of inquiring, in the broader set of norms governing inquiry. Friedman (forthcoming) calls such norms 'zetetic', though others refer to them as 'intellectual ethics'. I do not engage here with a substantive discussion of how we ought to conduct ourselves as epistemic agents, aside from the current point, but I the challenges relating to mental ill health and epistemic conduct are discussed in Chapter 5.

justified, or prudent. For example, an individual who has experienced delusions who shares with the research team that the laws of nature really don't work in the ways they believe, because time can move this– and that– way, may well be sharing information about their experience of delusion that felt real to them, but it probably ought not to enter into shared spaces and guide testimony. We typically do not consider belief in time travel either rational, or well supported by empirical evidence. The difficulty for the research team will be, if co-control of a research project is ever to be realised, determining which lay experts appropriately possess knowledge, and moreover, when and whether that knowledge will aid and further the goals of research. This would be difficult in a town planning study. In mental health it is that much more complex. Some writers have explored the ways in which our neural pathways can be re-programmed in the grasps of mental ill health episodes, which can affect what we believe, and know to be true. In patients with anorexia nervosa, for example, it has been shown that some patients really do feel better, when they lose weight, restrict their diet, and when seemingly negative consequences of the eating disorder arise – their neural pathways have re-directed such that a behavioural feedback loop forms, which rewards further 'progress' in weight loss or restriction (Walsh, 2013; Handa and Fulford, 2023). And in the fictional example I gave of time-shifts above could well be something that the individual has a persistent belief in, even if now 'well'. Discernment, then, will be required, to seek out the right experts by experience.

Prudence, then, in our conduct, our inquiring, and our selection of the right candidates to take part in coproduced research, could be one avenue which might give rise to doubt or disbelief in an individual with lived experience's testimony, which could be apt. In such instances, I do not think it fair to say that an *epistemic injustice* is committed – perhaps we should not believe, or give credence, to the testimony of all experts by experience, in all circumstances. In cases where we rightly disbelieve our interlocutors, that disbelief might, itself, be *just*, or at least justifiable.[32]

5 – Byskov's 'epistemic condition'

Consideration of the role of knowledge in discussions of epistemic injustice though, is not entirely novel. To address the plethora of accounts of epistemic injustice, and some of the related criticisms of the concept as being too widely applicable, some have argued we must do more to tighten the conditions for such judgements (Harcourt, 2021; Byskov, 2020; Coady, 2012, 2017). Morten Fibieger Byskov (2020), aiming to do just this, argues for an extended version of Fricker's account, which proposes a range of conditions they argue should be met such that any particular dismissal of testimony might be viewed as an epistemic injustice. The goal of this, Byskov claims, is to:

> "identify a set of conditions through which it is possible to eliminate cases of epistemic disadvantage that are not unjust and make it easier to systematically identify and evaluate claims of epistemic injustice"
>
> (Byskov, 2020: 116).

Byskov argues that Fricker's own work provides us with two conditions, which must be satisfied such that someone can be the 'victim' of epistemic injustice: that they are disadvantaged, and that they are experiencing prejudice (2020:118). The first condition avoids claims of epistemic injustice being levelled whereby a dominant group member is disbelieved on the basis of a stereotype which, though perhaps negative, does not form a pattern of discriminatory behaviour.[33] The second relates to the prejudicial stereotypes upon

---

[32] This of course does not constitute a claim that those with lived experience who we disbelieve should, or even might, share this view. I suspect that the majority of those who have experiences like those set out in 3.1. would feel strongly that they have experienced an injustice – mediating such disagreement falls beyond the scope of this present work.

[33] Here, I'm thinking of cases such as 'mansplaining', whereby a male could, in principle, attempt to tell a group of females about the menopause, for example, and find their credibility deflated because they are male. As

which Fricker's work relies (2007: Ch.2) To these two jointly necessary (but not individually sufficient) conditions for epistemic injustice, Byskov adds three additional conditions – the stakeholder condition, the social justice condition, and the epistemic condition. Here it is only the latter I am concerned with, for it begins to set the scene for the way forward I will take. On the epistemic condition, we must, Byskov argues, distinguish between those individuals who have a strong interest in a particular topic that a decision is being made about, and those who are epistemically qualified to be included in the decision-making (Byskov, 2018: 37-38). Mere interest – for example, being a user of a particular mental health service, and so wanting to be involved in discussions about that service's future, as in the anecdote from Bouchard (2019) – does not constitute grounds for inclusion, and could lead to "worse decisions" being made on the whole (Byskov, 2020: 125; Collins and Evans, 2008: 9-10, Byskov, 2017: 62).[34] And any coproduction project which includes users of a service only insofar as it wants a stakeholder-voice, as we saw in discussions of Arnstein's (1969) work, would not be properly coproduced. No, Byskov says, "in order to have the potential to be an epistemic injustice, it is additionally necessary that the excluded individual or group have relevant knowledge" (2020: 125). Should that knowledge be found lacking, then disregarding it may be a social or moral transgression, but it could not, Byskov argues, constitute an epistemic injustice.

I'm persuaded by Byskov's view for a couple of reasons. First, I do think that a distinction between mere interest-in and knowledge-of a topic, in the form of epistemic competence, is a distinction we must make. Being qualified to speak to the topic about which one opines

---

males remain a privileged group (all else being equal) this likely would not constitute an epistemic injustice. Or at least I'm inclined to think.

[34] Though see Byskov's (2020) five conditions in full, for arguments that such individual's may have a right to be involved as stakeholders – this right would not be tantamount to a right to be involved in coproduction, however.

may not ordinarily be a matter of much importance – many of us share our views on matters in which we are not especially learned in all sorts of scenarios – but for the context I am considering, knowledge matters. In mental health research, the knowledge produced as part of that research could go on to inform policy, treatment guidelines, or our understandings of how mental ill health originates (and perhaps, how to prevent it). Thus, the impacts upon the lives of individuals have the potential to be vast. As such, taking care in who one believes, and how research appropriately proceeds in ways which safeguard the interests of vulnerable individuals experiencing psychological (or psychiatric) distress, is imperative. And so, making room for voices who are not informed or qualified, in the right kinds of ways, would be ill advised.

The second reason that I am inclined to think Byskov's epistemic condition introduces a condition for epistemic injustice that we should take seriously, relates to prudence in our epistemic conduct, as outlined in 4.2. Imagine that I am in a break room at work, and I remark on the fact that I seem to have had a cold for months. My colleague, a white male, who I know to be a QAnon reading conspiracy theorist, replies, and tells me that the reason I'm constantly not well is because of the 'chemtrails', which governments are using to spray chemicals on us unassuming citizens. He goes on to tell me that the vaccination programmes prime us for susceptibility to the chemicals which are fed into aeroplane systems and then spread in the air as the planes fly. This, it may surprise you to know, is not my understanding of aeroplane exhaust trails, or of vaccination programmes. My enduring cold is nothing more than a combination of bad-weather and bad-luck. And so, what do I do, in the face of the testimony that my colleague has given? Well, there are a few things to say. First, whilst some could and would argue that a white male would not meet the discrimination condition, as men are usually a societally dominant group, which I would concede, I think it matters not for this example what the ethnicity of my fictional colleague is. Let's assume that he, in some way, is a part of a group who societally faces patterns of discrimination. Let's also assume that in determining how much credence to afford his testimony, I rely on a heuristic aid, that is to say a stereotype, that conspiracy theorists are ordinarily ill-informed. This is, surely, a prejudicial stereotype – it's certainly not a positive one. And so, we could argue that this also satisfies the prejudice condition. But, does my colleague meet the epistemic condition? I argue not. He may be interested, but he certainly is unqualified to give me medical advice, or to remark in a meaningful way on my illness – he may be interested in it, insofar as it presents an opportunity to share a (misguided) theory with me, but he has no knowledge of my health, or anything else of relevance to the matter, or at least, none which I am willing to recognise. In that kind of case, *epistemic prudence*, or the norm of being *epistemically continent,* suggest that I would do better and be a more effective inquirer by assigning no or limited credence to my interlocutor. Instead I should look elsewhere for answers (Code, 1987; Hookway, 2001). (This, I want to say, is because my colleague, in the context I am considering is not *epistemically competent* in matters of my health. That is, he is not an expert.) And, as I will go on to argue in Chapter 2, expertise, and whether patients can indeed be considered to have it, is the crux of the issue here.

As far as my interlocutor is concerned, not only do I think we can argue that he does not experience an epistemic injustice, because he does not know, or is not qualified, to speak to the topic at hand, but I think we can also say that I, as an epistemic agent involved in an inquiry of my own, should not believe him. What you know matters, or perhaps better *should* matter, when it comes to determining whether you should be taken at your word.

The upshot of this, of course, is that to determine whether it is apt to consider the cases set out in section 3 of this chapter as instances of an epistemic injustice, we must consider whether those with lived experience can be *epistemically competent* in the topics being researched. If such competence or expertise is not at least in principle possible, then the sorts of cases I focus upon here are likely not epistemic injustices. This, of course, rests on an acceptance of Byskov's extension of Fricker's work, though I find the arguments relatively uncontentious, at least in theory. Failing to assign high levels of credibility to individuals who do not have the necessary skill, qualification or experience to be considered learned on the topic about which they speak should not be considered unjust. Or, at least not in any epistemic sense. Instances of not being afforded credibility not always being considered epistemic injustices, however should not be taken as an indication that there is not harm being done in numerous other ways. It does seem fair to assume that if we invite an individual with lived experience to take part in research, that we believe they should have knowledge to contribute. This, by extension, may well generate an expectation that such invitation should be accompanied by a willingness to believe them, or take their view seriously. False promises in relation to a willingness to treat individuals with lived experience credibly, then, even if not epistemically harmful, are likely to be considered moral transgressions at the very least, and no doubt damage relationships and trust irrevocably. If that were to be the conclusion of further discussion, what this means is any injustice would not be situation within the epistemic domain, because it would have transpired that the individuals we harmed, would not in fact have known anything we would be remiss to ignore.[35]

---

[35] This does seem to indicate that there ought to be a threshold, or a pre-determining of whether a particular individual 'knows' in the right kinds of ways, before being invited to take part in coproduced research.

6 – Concluding remarks

This chapter then, has set the scene for what follows. I began by introducing coproduction as a research methodology, and by drawing out one of its key components: the need for power-sharing and a move away from traditional power imbalances between clinicians and academics, and those with lived experience. I then, however, presented a number of vignettes, reflections, and anecdotes, about the ways in which those with lived experience have found coproduction, or research involvement lacking. These include the distortion, subversion, or interpretation of testimonial content, or the pathologisation of lay experts themselves, based on their presentation whilst giving their testimony.

I also highlighted that there is an understandable tendency within extant discussions of credibility, disbelief, and misconduct with respect to such testimony, to make sense of this using Fricker's concept of epistemic injustice. However, where I diverge from such theorists is that – and as discussed in sections 4 and 5 of this chapter – I am of the view we must determine whether we should believe the individual we discredit. Norms of inquiry guide us in the way of *epistemic prudence* such that we can be considered *epistemically continent* agents. Taking seriously testimony, which informs knowledge, where the testifier is not in a position to know, I argued, would be epistemically ill-advised. As such, for the cases upon which this thesis focuses, further exploration of whether those with lived experience can be considered *epistemically competent* with respect to the topics they discuss, is required. This epistemic competence, as I'll go on to argue in chapter 2, is closely related to the concept of expertise. And, whether those with lived experience have such expertise will determine how we might make sense of the negative experiences of research involvement that such individuals have shared. If we can show that those with lived experience possess either expertise, or epistemic competence, then we might further explore the concept of epistemic injustice in the kinds of cases I have set out. If we cannot, then there might still be harms in coproduction, but such harms would not be best understood as epistemic injustices.

Chapter Two: **Epistemic competence and expertise: can patients have it?**

1- Introduction

In this thesis, my focus is upon the exclusion of individuals with lived experience in coproduction. Such exclusion occurs not physically, but with respect to the ways that knowledge they share is able to make it in to collective domains, as part of a project in knowledge production. Whether we should consider such cases instances of epistemic injustice, and if so, which theoretical framework is best placed to explain the harm at play, of course, is the primary purposes of my discussions. To claim that there is an injustice, though, I've argued in line with Byskov (2020) that we ought to evidence that such experts do indeed know a sufficient amount about the topic on which they speak. Such knowing, I ended Chapter 1 by saying, would need to take the form of either *epistemic competence*, or of *expertise*. This chapter asks the question: can individuals with lived experience, in the absence of clinical training possess such expertise?

I'll proceed with the discussion as follows. In section 2, I'll discuss the concept of 'expertise by experience' and in doing so, will distinguish it from lay expertise. Providing a range of ways we might unpack the concept of expertise by experience, I'll say, is helpful in further allowing us to determine whether we might consider practices discussed in Chapter 1 as epistemic injustices. I will argue that expertise by experience is plausibly intended to signify a specific sort of epistemic competence. Section 3 then considers what differentiates epistemic competence from expertise, by exploring in a theoretical sense, what it might mean to be an expert. Drawing on Goldman's (2016) account of expertise, I'll agree that expertise is domain specific, though the conditions for developing expertise can vary depending on the domain in question. Expertise can, of course, be acquired through formal training, but so, some argue, can it be developed on the basis of experience. In section 4, I explore discussions of experientially acquired knowledge, and ask whether it can give rise to expertise. Drawing on Cath (2018) and Faulkner (2021)'s discussions the unique kind of knowledge which experience gives rise to, I'll argue that there are reasons to take seriously the possibility that experience provides one with an understanding of the what-it-is-likeness of that experience, that theoretical or academic study cannot.

Section 5 begins to explore the existing views relating to 'patient expertise'. Arguments for and against the possibility of such expertise will be considered, as will the plausible breadth of that expertise. Consensus on the matter, however, is something I'll concede we are far from reaching. Lastly, in section 6, I relate the discussions to the domain of mental ill health. Mental health, I'll say, is complicated, and the theorists who argue for the plausibility of patient expertise in relation to physical health, may not have intended those arguments to translate to a domain which so closely relates to psychological function. However, I'll say that based on the arguments set out in favour of patient expertise for physical health, and with the caveats relating to stability or recovery added, which Chapter 1 discussed, there is no reason to suppose that patient expertise in the domain of mental ill health is not possible. This will not, I'll say, settle the matter of which patients should be considered experts, or how to adjudicate on disagreements between experts, but it does mean that assuming diligent recruitment of experts by experience has taken place, we might well consider the exclusion of their views as in some way preventing what they know from having effects on knowledge production. And with that established, it *is* possible that the experiences of such experts by experience, as seen in Chapter 1 s.3.1., might constitute some sort of epistemic injustice.

2 – Expertise by experience

In the introductory section of this thesis, I stated that for the sake of consistency, I would refer to individuals with lived experience of mental ill health as ‘experts by experience’. It may not, then, have slipped your attention that throughout chapter 1, I instead used the phrase ‘lay expert’, to refer to those involved in coproduction who have had contact with psychiatric health care professionals. And the reason I have not yet used the phrase ‘expert by experience’ in any sustained manner, is because first, building on the final sections of the preceding chapter, I believe a further examination of *expertise* is required. This is largely because, without presupposing arguments to come, I believe there are a number of ways in which the phrase expert by experience could plausibly be used, and a number of intentions which might underlie each use case.

Here, I keep discussions intentionally short, as it is difficult to approximate all of the ways that any given research team may use the phrase. I do, however, wish to set aside some of the possible meanings of the term, and gesture towards others, returning to them later in this chapter. In undertaking a discussion of the possibility of patient expertise, I think it only right to ask whether we (a) are really signifying a specific kind of expertise by using the phrase, or whether:

(b) We seek a way to differentiate traditional members of the research team from non-traditional members, which does not sound demeaning or othering, but which recognises that their role is not the same as academics or clinicians and signifies their involvement as being for appearances alone?

(c) We are equivocating the notion of expertise by experience with lay expertise, which appears similar to (a) but could importantly reflect that experts by experience aren’t really recruited to research for their *experience* at all, but based upon their knowledge of the research landscape, despite being a member of the public, and not a 'traditional' researcher?[36]

(d) Expertise by experience is a signifier for contributions which, though derived from lived experience, are to be treated as anecdotal, as opposed to scientific and factual?

Realistically, any given research team could use the phrase in any one of the above ways. However, because we're talking about coproduction, and because coproduction requires power-sharing (though not necessarily equally at each and every stage, as I'll discuss in sections 5 and 6, I think that we can say that (b) and any use of the term expertise by experience in this manner, cannot relate to a coproduced research project. Nothing in (b) indicates any intent, or even reason to, share power or to recognise a different kind of knowledge (and in fact it presumes there is little knowledge indicated by the concept). (b) may introduce a moral harm, in the sense of mis-representing the degree of involvement on offer to the experts by experience recruited, but it indicates a lack of intent to take seriously individuals with lived experience. Such cases, or uses, then I set aside insofar as I assume we are not usually using the phrase expert by experience in this way.

To (a) and (c) and (d), I will return, as these are, on my view, slightly more plausible options that may be concomitantly in use. (c) though, I'll say, isn't expertise in a meaningful sense, at least not insofar as it relates to knowledge production and the role of experts by experience.[37] Rather, recognising that some individuals are involved in multiple research

---

[36] Castro et al (2018) too find that 'lay expertise' is distinct from expertise by experience, following Civian et. al. (2009) and Thompson et al. (2012).

[37] Defenders of the notion of lay expertise would likely disagree with my construal of it in (c). Introduced in the 1990s to refer to patient knowledge, but intended to demarcate that knowledge from knowledge had by clinicians, however, the depiction of it, given what I'll go on to say of expertise by experience, does not strike me as overwhelmingly problematic. On discussions of lay expertise, though see especially: Blume (2016).

projects, and thus understand how research works, how to speak 'the language of academics', and what the goals of research are, in terms of outputs, and the like, (c) may be a way of referring to individuals who do not necessarily have lived experience, but are skilled in advising academics and clinicians about their approach from the perspective of a member of the public.[38] I do not think, however, that individuals who do *not* have lived experience of mental ill health, and who still feel as though they have not been treated fairly in coproduced projects, are experiencing all of the same things that I'll spend the rest of this thesis applying to those *with* lived experience. As such, whilst I'll show in section 5 that expertise in the domain of being a member of a research project, is not implausible, I largely set such use-cases in what follows.

And so, that leaves us to consider more fully:

(a) We really are signifying a specific kind of expertise by using the phrase expert-by-experience; and

(d) Expertise by experience is a signifier for contributions which, though derived from lived experience, are to be treated as anecdotal, as opposed to scientific and factual.

Both of these options, I'll say by the end of this chapter, are potentially ways that expertise by experience is commonly used, though the arguments I give in section 6 attempt to motivate the claim that (a) should be the preferred way of understanding expertise by experience. (d), I'll say, undermines the concept of expertise in many ways, by distinguishing

---

[38] This may strike you as an implausible use of the phrase 'expert by experience'. However, there are two things to say in response: first, coproduction does not require that individuals who are not traditionally qualified experts have themselves first-hand experience with the condition or illness or set of social circumstances being researched. Rather, it requires the bringing together of relevant stakeholders. Having experience with the healthcare system broadly, without ever having had contact with psychiatry, could very well be considered appropriate for service design-type research. Nothing in the discussions of coproduction, either in chapter 1, or elsewhere, preclude tangential experience from counting when it comes to determining stakeholders. Secondly, these individuals could still be considered 'experts by experience' if that experience were previous involvement in research. This could be a less common use of the term, but I think it possible it is used, in some contexts in this way.

experiential knowledge from ‘real’ knowledge – which really is the subjectivity/objectivity debate that pervades science, and which I briefly touched upon in Chapter One. This serves to create a two-tier approach to research, while the domain view set out in section 5 negates the need to do so.

3 – Expertise, epistemic competence and knowing better

What expertise *is* then, is integral in our ability to get clearer on what we mean by expertise by experience. And we might begin by considering what expertise does.[39] Having, or seeking expertise, helps us to efficiently approach, address, or resolve problems. It can also help us in determining whose advice to take, or to judge whether someone is qualified to aid us with a problem. Practically, consulting the experts on a subject might look like seeking out a doctor when we are unwell, deferring to those who have amassed more experience or who are perhaps more skilled in complex matters when it comes to resource allocation, or, even, hiring someone to do electrical work that we cannot undertake safely ourselves. Hanna Metzen (2024) in considering the importance of expertise says of the concept that it is:

> “needed for solving practical problems and often serves as a basis for political decisions. At the same time, especially in more formal scientific policy advice, political authorities can for example appoint members of an expert group or determine questions that need to be answered”
>
> (Metzen, 2024: 58).

Christian Quast (2016) similarly argues that there is value in expertise, and that it allows us to:

> “substantially improve the social deployment of available agential resources apt for client(s’) relevant ends”

---

[39] Here, ‘does’ I use functionally. I’m not attempting to understand the semantic or propositional content of ‘expertise’, if you are of the view that we could tease apart use and meaning.

(Quast, 2016: 18).

Thus, not only is there a significant role for expertise in society, but being able to trust such expertise is imperative in order that the concept can appropriately function in ways which we can place faith in (Metzen, 2024). On Quast's point, being able to recognise an expert requires that we appropriately recognise the limits of our own abilities, and to determine the most apt use of our resources. The most appropriate means of deploying our available resources might, in some cases, be to outsource our quandary to someone else. Any expertise we might 'contract' then, to facilitate efficacious resource deployment must be appropriate to the task or problem we seek to undertake or resolve. If I seek someone to fix my oven, I'm wasting my time, *ceteris paribus*, if I approach an expert in global economic theory. I'm likely not going to be able to bake my dinner, and the economist would almost certainly be happier and more successful conducting market analysis. Desiring efficiency, and effective deployment of our money, time, and indeed energy, as well as, in the case of the doctor, our continued survival, then, drives our need for expertise. Sometimes, we need a professional opinion and that professional opinion had better be skilled in the area of our concern. Acquisition of expertise though, such that you might be called in to fix a problem or issue, is not happenstance. One may discover a love or passion for a topic accidentally, but, as we'll see, expertise tends not to develop or arise from fleeting, or momentary, acquaintance with a particular topic.[40]

---

[40] There is some disagreement with this position, insofar as some individuals with autism have occasionally been considered to have impeccable natural talent or skill in a particular field; music, being one example (see Ericsson and Pool, 2016, for more discussion of this). However, the notion of the *savant* is contentious, and I'll proceed in what follows without considering natural aptitude to a great extent. Of course, one's intellectual ability will affect in what fields one could become an 'expert' though I think this not particularly pertinent to the discussion that follows.

3.1- What *is* it to be an expert?

Functional analyses of the use of the concept 'expertise' like those in section 3, get us to an understanding (however basic) of the utility of the concept. Our purpose here, though is not rooted in functional argument, but is to get to an understanding of what expertise is, and whether individuals with lived experience could be said to have it. And for this, we need to undertake at least rudimentary conceptual analysis of *expertise*.[41]

At a very basic level, we might construe expertise as relating to what one knows in relation to a particular topic or about a particular discipline. Or, perhaps more aptly, expertise might signify the level of competence that one possesses when attesting to the right, best, or truest, fact or skill to resolve or address the question at hand. If for instance, I have read philosophy for ten years, then I might be considered a more likely candidate-expert than someone who has never been introduced to philosophical thought. But, it's plausible (and almost certainly true) that someone who has read philosophy for much longer than I will be more knowledgeable, and by extension, would be a wiser choice if one sought an expert in Humean laws of nature. Time spent on a topic tends to correlate with knowledge about that topic.[42] Possessing knowledge, though, is a tricky way to consider expertise: how do you measure or quantify who knows best, and thus who might be the better candidate if you find yourself suddenly in need of a philosopher?

Perhaps because of the difficulty in measuring expertise, we often do not think about it solely as possession of knowledge, though of course that forms a part of the story. Largely,

---

[41] I say rudimentary, as epistemology is increasingly interested in what expertise is and consists of. It is far from practicable to give a complete overview of those discussions here, and so I do not attempt to do so. Rather, the understandings of expertise that I do consider allow us to proceed with additional exposition relating to expertise by experience.

[42] Some, for instance, have argued that being an expert requires thousands of hours of dedicated study. See, for example: Ericsson and Pool (2016) and Ericsson, et. al (1993).

we're also interested in who is able to deploy that knowledge in successful ways the majority of the time. This, according to Oliver Scholz (2016) is a *symptom* of expertise, and symptoms of expertise, he claims, are more practical for the purposes of determining whether one is, indeed, an expert that abstract supposition. However, not all expertise is necessarily demonstrable – skill-based expertise, for instance in electrical repairs, may be something that we can measure based on the ability of the electrical engineer to repair my oven, but expert opinion often relates to matters which are not veritable. That is, there is no truth-of-the-matter that we have any epistemic access to, which could settle the debate of who knows best (Watson, 2016). The example I gave of expertise with respect to Humean laws of nature, would be a kind of expertise of this nature. I might be better positioned than another to answer questions about Hume's work, but there is perhaps no fact of the matter which determines whether my understanding is indeed *true* or right.[43] This, according to Jamie Carlin-Watson (2016) is an example of cognitive expertise (p.40), which Alvin Goldman also calls "intellectual expertise" (2001: 91).

Broadly, cognitive, or intellectual expertise then relates to knowledge, and the possession of justified (true) belief on some topic or other, as well as the ability to correctly deploy that knowledge, most of the time (Goldman, 2016). Goldman thus gives a view where one construction of expertise would be as follows:

> "S is an expert about domain D if and only if (a) S has more true beliefs (or high credences) in propositions concerning D than most people do, and fewer false beliefs; and (b) the absolute number of true beliefs S has about propositions in D is very substantial" (2016: 5).

---

[43] Though I accept that there may be a fact of the matter about whether my interpretation of Hume is false, insofar as I could misrepresent his position in a way that other experts might argue is to miss the overarching point of the discussion.

On this view, expertise consists in having better – in the sense of true, or credible –beliefs relating to a particular topic than someone else, and, in sum, having more such beliefs than others. For Goldman (2001, 2016) the truth of the matter's accessibility to us is incidental; whether we can or cannot accurately verify the expert's testimony does not bear on the question of whether they *have* expertise. We may well never be able to ascertain, in a truth-linked sense, whether those we think are experts were indeed 'right'. To this, Goldman says: "such is life" (2016: 5). This, Watson refers to as Goldman taking a "God's-eye" view of expertise (2016: 48, Goldman, 2016: 5). Such a view, where we are unsure how much credence to afford to knowledge shared by an 'expert' which is unverifiable, this may present us with problems. This is the issue that the symptoms based account of expertise (Scholz, 2016) attempts to side-step: it is not what you know, but how you behave, or demonstrate such knowledge, which counts. Watson (2016), having similarly raised concerns about the unverifiability of much expert testimony, instead offers an *epistemic facility* account of expertise whereby:

> "A subject, S, is an expert in a subject matter, M, if and only if S (a) understands a substantial proportion of the terms, propositions, and arguments in M, along with the procedures used to formulate propositions in M, and (b) S has the ability to demonstrate (a) successfully in the discharge of her epistemic activities"
>
> (Watson, 2016: 46).[44]

The idea here, is that an individual who meets both (a) and (b) is far more likely, on balance, to have a larger number of justified beliefs with respect to a topic, than an individual who fails to satisfy either, or both, condition(s). This could, though Watson does not argue along such lines, be understood as a competence in both reaching, and in communicating, well-reasoned points of view. In my philosophy example, this could be taken as knowledge of the

---

[44] I understand subject matter (Watson, 2016), domain (Goldman, 2001, 2016) and topic, as I have used the phrase thus far, to be speaking about roughly the same kind of thing: the area in which one's knowledge is concentrated.

ways in which reasoning is carried out to a conclusion in the analytic tradition, an awareness of surrounding literature, and a dissection of Hume's work, all of which I am able to draw upon to then communicate to others intelligibly.

Competence, though not sufficient for expertise, is also understood differently by different thinkers. For some, being epistemically competent depends only on the knowledge one possesses and is unrelated to the deployment of that knowledge in the right kinds of ways (Goldman, 2001; Coady, 2012). Others, however, think that both performance (and consistency in that performance) and knowledge are required such that you might be considered epistemically competent with respect to some topic or other (Watson, 2020). What we know is then important. So too, however, is the way in which we have come to know it. For Watson (2016), the procedural aspect of knowledge acquisition, for instance, understanding why we reason in particular ways to come to certain conclusions, is an important facet of expertise. Whether such knowledge is required could be contested, though. Piano playing 'by ear', as opposed to in the knowledge and understanding of musical theory, might be an example we could appeal to here. An incredibly skilled pianist could be considered an expert, I think, in piano playing, irrespective of their sheet music reading abilities. Sometimes, we can demonstrate skill (or expertise) with respect to a topic, without necessarily having an understanding of that topic, for instance, by practice over time. This, importantly, is not the same as accidental or coincidental acquaintance with a topic which affects our epistemic position – this, Fricker (2006) calls one's *epistemic placement*. There are, of course, times where my placement in time can give me unrivalled access to a particular phenomenon which I can competently speak about, or attest to, in ways that others cannot. Fricker gives the example of a meteor shower, which one happens to witness, from an excellently placed vantage point, and talks of the ways in which this situatedness allows you access to the meteor shower in ways that your friends, standing elsewhere, cannot. Being able to relay to them precise testimony about the meteors you can see, though, is coincidental: you could have easily been elsewhere. This, Fricker says, is an example of where epistemic placement gives rise to a *thin epistemic advantage* (2006). I could have been elsewhere, and nothing that has led me to be where I am, and thus my being better placed to speak about the meteor shower than you, is rooted in any kind of skill, or study. Watson argues (2023) that this is not the same, or epistemically equal to having a *thick epistemic advantage* (Fricker, 2006) which is based upon a knowledge or understanding of – in the meteor shower example – my awareness of gravitational pull, light refraction, and the like (2023: 5). This latter sort of advantage likely does not appear by accident or happenstance: it arises on the basis of repeated and sustained effort, and thus, can be considered competence, to a greater or lesser degree. Expertise, as defined by both Goldman (2001, 2016) and by Watson (2016) then, could be understood to be situations whereby one develops a thick epistemic advantage, on the basis of sustained effort, or situation, which makes one epistemically competent in attesting to a particular subject matter. The point at which such competence tips over and becomes expertise, will depend on one's stance on veritism and its place in such theory. For Goldman, such a point would arise when one has more true-beliefs or high credences than non-experts, and for Watson, when one has reasoned in accepted ways, based on available evidence, to arrive at particular views, and had repeated successes in communicating those views (as a demonstration of ones' mastery) to others (Goldman, 2016; Watson, 2016).

Even within a domain, there may be differing degrees of expertise. Knowledge is, oftentimes, relative. A newly qualified surgeon, for example, might be less of an expert in matters of diagnosis than her clinical specialty lead, but, depending on the specialty lead's proclivity for further learning and development, the younger surgeon might be considered to have more expertise in innovative surgical procedures (due to the recency of the training they have undertaken).[45] But, for either surgeon, or clinical specialty lead to be considered experts in medical fields at all, some would argue they must meet minimum standards of practice. Such minimum standards are often said to be the standards of admittance to the comparison class of experts, and whether there exist such standards will differ depending upon the domain in question. In medicine, one would hope that minimum standards would include some professional certification and training (Watson, 2020). Dreyfus and Dreyfus (1986) conversely argue that performance alone is sufficient for expertise, leaving open the conditions for its ascription to others. But, there are some cases – medicine being one – whereby a minimum bar does seem appropriate. Watching over a thousand hours of *Grey's Anatomy*, for example probably does not give one the required knowledge and skill to conduct an appendectomy, the 'knowledge' I would have amassed by doing so would not rival that of a surgeon. This sort of position has led some to argue that *all* medical knowledge is of this nature: best left to the professionals. Such views express disquiet at the very notion of patient expertise (Shaw and Baker, 2004; Nichols, 2017). And the concept of patient expertise I will return to in section 5 of this chapter. For now, though, we have arrived at the question of whether one can become an expert without formal training. On this, Goldman (2016) says:

> "we do not restrict expertise to "technical knowledge". The definition does not confined expertise to scientific domains, nor require experts to have specialised training (although such training is a common pre-condition of many types of expertise). Someone interested in the history of opera, for example, might become an expert under her own scholarly steam rather than through a series of academic classes"
>
> (2016: 4).

---

[45] Watson (2016) echoes this point with a similar example (p.41).

This then, introduces the potential of expertise via self-tuition. Though I argue this should not be a possible entry to expertise in the practicalities of medicine, as well as other domains which are likely to require similar robustness in qualification, Goldman's view is that acquisition of knowledge need not be limited to formal academic training. History of opera, cited above as an example of this, might be taught to oneself drawing upon textbooks, recordings, documentaries, and the like, without ever stepping foot into either a classroom, or, perhaps even, a concert hall.[46] Why might Goldman think this? I cannot say for certain. However, I suspect that what rides on whether your expert gets it right or wrong, may have a role to play. If one errs and confuses an aria with an arietta then you may feel a fool, and may undermine your own reputation (and no doubt damage your pride somewhat), but the error is not lethal. In fields such as medicine, or for roles such as a pilot, or aircraft controller, the stakes are much, much higher, and errors can, and do, have grave consequences. And this tells us that domain matters a great deal. Where the stakes are incredibly high, and, importantly, where our experts are responsible for execution of a task which requires expertise to such a degree that their failure could have dire consequence, there ought to be minimal standards for admittance to the comparison class. For other areas, though, acquaintance, whether by self-study, or, as I'll go on to discuss in the next chapter, experience, may suffice to allow knowledge to be amassed which gives one a thick epistemic advantage, leading to a high level of competence. That competence, on many of the views I have outlined here, could well be considered expertise.

The final point to note, before moving on to a discussion of knowledge (and expertise) derived from experience, is that domains themselves can be 'split', and one can be

---

[46] I might, of course, be less concrete in this assertion if discussing the matter with an esteemed historian of opera!

considered an expert in a sub-domain to a greater degree than one is considered expert in that domain on the whole. Take the philosophy example again: imagine I am a social epistemologist. Does this make me an expert in philosophy as a whole? That depends. If, the reference class of those being considered includes myself, and ten others who have never studied philosophy, or the analytic philosophical tradition, at all, then what I might know about Humean laws of nature, or at least the ways I am able to reason to conclusions regarding those laws, may be considered epistemically superior to the others in the class. It is not my area of specialism, however, and so I would argue (quite strongly) against the plausibility of my being considered an expert. Rather, I might be considered to have a thick epistemic advantage with respect to philosophical arguments and methods, which allows me to reason to a sensible conclusion about Hume's views. Could I, faced with a question about 'knowledge', be considered an expert? Well, again, it depends upon who is in the relevant comparison class, but should I be in the same group as before, then this time, my knowledge of epistemology-proper would likely render me much more able to claim expertise of a sort in that domain. It is closer to the sub-domain in which I have greater expertise: social epistemology. This is not to say that there are not other social epistemologists whose knowledge is far more developed than my own, even in social epistemology; philosophy, as with many other fields, is a vast subject, and I would argue that no one can be considered an expert in every single sub-domain. The ways in which I may reason to a conclusion in the broader domain may mean I'm often able to give high credences in conclusions I reach, but the knowledge I possess some of the specifics is extremely limited. Medicine, I would argue, is no different: if one has medical training, there are likely skills which every doctor must possess, including basic life-support, resuscitation, cannulation, and so on. However, if a gastroenterologist has spent 18 years specialising in his field, his expertise is far more developed in that field, than in medicine on the whole. He may, because of the medical training, be able to derive sensible and informed conclusions from clusters of symptoms, but if you ask him to perform brain surgery, he will likely direct you to a neurosurgeon. And what this shows is that within broad topics, mental health included, there are differing ways in which one can know, and varying levels of expertise one can have with respect to topics. Greater specificity in a domain will lead to fewer individuals who might claim to be experts (due to the need for specialisation in a very specific, particular field). This, I would argue, can only be a good thing, insofar as it allows ones' knowledge to be restricted and developed in nuanced and relevant ways.

What this gives us then, is a picture of expertise that is something like the following:

Expertise relates to epistemic competence in the form of knowledge or skill one has, with respect to a particular topic, *t*, situated within a broader domain, *D*, such that one is reliably able to attest to matters relating to *t*, and possesses, by comparison, more justified beliefs about *t* than most people.[47]

This, I do not intend to be read as a philosophical account *of* expertise, as I have not attempted to resolve the tensions between Goldman and Watson's views, or settled the question of what 'grounds' expertise.[48] However, for our present purposes, it suffices as a view which leaves open both the ways in which one might acquire expertise, and the specificity of the domain in which one possesses it.[49]

---

[47] Whilst I use justified belief here, I leave open whether a definition of expertise should rightly require appeal to veritism.

[48] Rather, in an almost Hanslanger-ian sense of ameliorative inquiry, understanding expertise in this manner allows it to fulfil the relevant conceptual void for us in what follows. For more on ameliorative projects, see, especially Haslanger (2012), Barnes (2016).

[49] For instance, there *might* be domains in which one's topical expertise extends to the entirety of the domain, though I cannot think of such an example.

4 – Knowledge by acquaintance: what-is-it-like*ness*

Goldman's view above, then, leaves space for knowledge (and expertise) which does not have formal education as a pre-requisite. Whilst Goldman is talking of expertise acquired on the basis of self-study, it does leave open the question: does experience give one expertise? To answer this question, let's revisit the case of Mary (Jackson, 1982). Constructed as an argument against physicalism, the case of 'Mary' shows that some knowledge cannot be acquired from study alone, but only from acquaintance with, or experience of, some subject (Faulkner, 2021). In the classic example, Mary, a talented scholar, residing permanently in a black and white room, learns all there is to learn about the colour red. She understands light fragmentation, perceptual vision, and so on. There is nothing else she could know about red, presuming that all knowledge can be acquired without experience. Yet, when Mary leaves her black and white room, and sees a red tomato, she *experiences* something new, and learns what the phenomenological experience of redness is (Jackson, 1982: 130-131; Faulkner, 2021). This knowledge, Faulkner (2021) argues, in line with Lewis (1999) that what Mary experiences is the 'what it is like-ness' quality that experience gives us.[50] This experience, and the knowledge or feeling it gives to us, is subjective – it is a personal *feeling* one has when experiencing this thing in particular. For Mary, that 'thing' is the colour red. For others, it could be the taste of a particularly divisive food item.[51] But there is some agreement that having an experience for oneself gives rise to, or makes way for, a particular phenomenal experience which cannot be derived from theoretical learning alone. This is true irrespective of how expert one's theoretical knowledge in relation to that experience is.

---

[50] Some refer to this what-it-is-like*ness* quality as *qualia*. Jackson's (1982) work has an extensive discussion of this, which is further discussed by Lewis (1999) and Faulkner (2021).

[51] For instance, David Lewis (1999) refers to the taste of Vegemite, saying: "you may have tasted Vegemite ... I never have. So you may know what it's like to taste Vegemite. I don't, and unless I taste Vegemite (what, and spoil a good example!), I never will" (1999: 263).

Yuri Cath (2018) argued this point, making the claim that only those experiences which we ourselves have can be said to be ones about which we have top-tier, or gold standard, knowledge: the most robust kind, on his view.

The relevance to the present work of these debates, is to illustrate the common acceptance of knowledge by experience: theorists largely do not disagree that there *is* some knowledge which we simply cannot claim to have unless we have lived the experience to which it pertains.[52] And, it seems uncontentious to suppose that having lived experience of mental ill health, could generate experiential knowledge, which importantly differs in its content to theoretical or clinical knowledge. In fact, some feminist philosophers have criticised the traditional epistemological qualification of knowledge as being only justified or true belief, on the basis of embodied knowing, such as in the case of mental ill health (see, Code, 1991, for example). Knowledge derived from experience, however, might be presumed to be subjective, concerning only one's perceptual, perspectival, or felt life. As Thomasina Borkman (1976) argued, experiential knowledge:

> "is truth learned from personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation, or reflection on information provided by others"
>
> (Borkman, 1976: 446).

---

[52] Here it would be remiss of me not to mention the scepticism that many have also argued for with respect to the transmissibility or relevance of that knowledge, when communicated via testimony. Especially pertinent examples of this relate to moral or aesthetic testimony, whereby personal appraisal of actions, or of works of art give rise to experiences of those actions or artworks. Whether we can ever communicate our views on such in a way that allows our audience to similarly claim "the film was really good" without having seen the film themselves, is where sceptics are especially pessimistic. In what follows I will mention the training programmes available to experts by experience relating to in what ways they might frame their narratives. I will not, however, take a view on whether co-researchers can be said to *know*, either at all, or to a similar degree, the same things as experts by experience, after hearing their testimony. Since coproduction is a collaborative project, though, I am of the view that how one answers this question matters not. For more on testimonial transmission (or the impossibility of this) however, see especially: Cath (2018),Hills (2009), Hawley (2010), Hopkins (2007,2011), Faulkner (2021), Malantes (2011), Meskin (2004).

Personal experience, though is often not considered ‘scientific’, as already discussed in Chapter 1: there remains a pervasive belief in the need for objectivity in scientific ‘method’.[53] This does not differ in psychiatry (Tekin, 2020; Regier et. al, 2010). Thus, despite views which argue that there is merit in including knowledge about the what-is-it-like*ness*, in a felt sense, in scientific inquiry (at least insofar as it considers patients), there remains concern about whether there is a place for experientially acquired knowledge in health research.[54]

4.1- What can patients know?

Given such concerns regarding phenomenologically focused knowledge, it might be felt easier to not attempt to include it in research at all. However, such a leap would assume such kinds of knowledge are *all* that experience might give us. Is this assumption right? Şerife Tekin (2023) indicates that perhaps the answer is no, and that there are reasons we might suppose that patients amass knowledge which goes beyond the felt*ness* of illness (Tekin, 2023; Dings and Tekin, 2022). Focusing on a specific example of an individual with lived experience, Tekin says the following:[55]

---

[53] Tekin (2020, 2022) argues that the notions of both subjectivity and objectivity in science are complex, and appears to echo Alcoff (2012) insofar as she does not believe that introduction of subjectivity into scientific inquiry necessarily yields worse science.

[54] For arguments which implore the scientific community to include patient voice, see for example: Glasby and Beresford (2006); Faulkner (2017); Rose (2009); Russo (2014) and Sweeney (2015).

[55] The quote upon which Tekin (2023) focuses is taken from *Musings of.a Mad Activist* (2019) (written under a pseudonym) where the author says: “…it is very rarely, if ever, that I am treated as an expert. If I am treated as an expert, it is not because of my victimhood. It is because I am a PhD student, or an editor at a critical psychiatry web magazine, or a founder of a grassroots group that raises awareness about human rights violations. It is because of some position or title I have that is equated with productivity or empirical knowledge, with serving a population or doing work within the capitalist framework that is viewed as respectable, valuable, or most commonly monetizable. The reality is that while all of the above experiences have contributed to knowledge about mental health, human rights, and cognitive liberty, it is deeply personal experiences of human rights violations and victimisations that gave me the bulk of my expertise. It is not study, readership, or editing that enables me to viscerally feel the impact of psychiatric coercion and paternalism in every bone in my body; it is not intellectual or empirical knowledge that drives me to speak out. It is only my

> "To start with, she has experiential knowledge on the orientational challenges of her mental disorder, such as the feelings of psychic pain. She also offers an evaluation of how she responded to different treatments e.g. hospitalization, and what may or may not have worked. In addition, she has a grasp of how her experience with mental disorder affects other dimensions of her life, such as work and relationships. Finally, she is able to situate her experiences with the psychiatric/medical system in the larger context of human rights violations"
>
> (Tekin, 2023: 312).

Note, on this reading, what the individual with lived experience has is only in part comprised of phenomenological experience. In totality, the knowledge she has amassed extends far beyond the what-is-it-like*ness* of having a mental ill health diagnosis.[56]

Others too have argued that patients can and do develop knowledge from experience which extends beyond knowledge of one's own bodily feelings or emotions (Dumez and L'Espérance, 2024). Embodied knowledge does of course comprise an important aspect of the picture, as patients must be able to verbalise that embodied knowledge in healthcare settings, to communicate with their doctors. Tekin's quote shows, though, that competence can be developed too in relation to the domains of management expertise (of one's own symptoms, and of living with illness) and of peer-support (Price, 1993; Paterson, et. al, 2001; Brown, 1992). Knowledge from experience can possess then a range of properties, including the subjective, but which can give rise to unconscious *knowing-how* (Boardman, 2014). In fact, when it comes to discussion of expertise by experience in the literature, Dings and Tekin (2022) for instance, have argued that actually the what-is-it-like*ness*, in a phenomenological sense, is not even necessarily the knowledge that we are discussing in questions of patient expertise:

> "What is at stake here does not seem to be the what-is-it-like-ness… Rather it seems to be more about *what* the person encounters and less about *how* whatever is encountered

---

subjective experience of victimization – which I feel and relive over and over each day – that leaves me with no choice but to take action" (2019: 36).

[56] Tekin and Outram (2018) argue along similar lines, particularly with relation to the interpersonal difficulties which lived experience makes one intimately acquainted with in relation to mental ill health.

> affects that person's phenomenal experience… in practice, and what we see in studies, *ExpEx* seems to be about something else"
>
> (Dings and Tekin, 2022: 1422).

And nothing said thus far precludes the notion that experience cannot give rise to such understanding of *what* one has encountered. The felt-ness of that 'what' is the dimension which those arguing for the uniqueness of experiential knowledge would claim could not be acquired from study alone (Cath, 2018). For, certainly, I might read all there is to read about how I might be treated if I were diagnosed with Bipolar disorder, but it is unlikely that I would *know* sufficiently without the personal acquaintance that would surely come with encountering such a life-event. And it seems unreasonable to suppose beyond the bounds of a philosophical thought experiment that academics and clinicians could even claim to know all there is, theoretically, to know about receiving such a diagnosis. Rather, they will likely know more about the preconditions for, and subsequent management of symptoms associated with, that diagnosis.

This gets us to a picture then, whereby we might accept that experience gives rise to kinds of knowledge that study alone may not. The remaining question that this chapter seeks to ask, then, relates to whether such experientially derived knowledge might be ever properly considered 'expertise'. Then, and only then, might we be able to return to the potential understandings of the phrase 'expertise-by-experience' I set out in section 2, and determine how we should understand the concept.

5 – Patient Expertise

If we recall from section 3.1. then, to be considered to have a *thick epistemic advantage* with respect to a domain requires that any epistemic authority to which I may lay claim is based in more than coincidental, or incidental, epistemic placement. If I wish to make a claim to any kind of expertise in relation to a particular topic, it likely shouldn't be based on my situation in a given moment in time, if that situation could just as easily have been yours (Watson, 2023). The preceding section has given us reason to suppose that one's experiences may well allow for the development of thick epistemic advantage, with respect to the very experience in question. And, as I finished section 4 by discussing, others too have argued that this experience can give me access to more than just the phenomenological knowledge. In what follows then, I discuss the concept of patient expertise, which, I'll go on to explain, is what we're talking about in using the term 'expert by experience'.

5.1 – Competence: In what?

In 1999, the United Kingdom's Department for Health and Social Care (DHSC) published a white paper, which outlined the merit of listening to patients, and even affording them some epistemic authority in matters surrounding their own care (DHSC, 199). The white paper set out that:

> "people with chronic illnesses are often in the best position to know how to cope [with those illnesses]. There is increasing evidence from research studies and from patients' associations that people have improved health and reduced incapacity if they take the lead themselves in managing their chronic disease"
>
> (DHSC, 1999: 3.49)

This, capacity for knowledge surrounding one's own condition was further highlighted by DHSC, in '*The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century'* (2001). Here, authors explain that trials and pilot studies indicated that patients who took a leading role, as suggested by the 1999 report, "often knew their condition better than doctors" and were able to manage them with greater competence (DHSC, 2001: 5). And the role of governmental bodies in driving participatory research toward the landscape we see today cannot be underestimated. Note, though, that admission of the plausibility of patient expertise is not tantamount to a negated need for medical expertise. It is not even to draw an equivalence between the two kinds of expertise: the concept of patient expertise does not *require* that patients become medically trained.[57] As Shaw and Baker (2004) note, even training programs which target those with lived experience to help them become ‘patient experts’ do not aim:

> “to turn people with Parkinson’s disease into amateur neurologists or people with arthritis into hobby rheumatologists, setting them up to compete badly with doctors” (Shaw and Baker, 2004: 723).

This is not to say, however, that it is impossible for patients to acquire medical knowledge. Dumez and L’Espérance (2024) for instance, discuss emerging literature which suggests that patients can and do learn about medicine, physiology (or psychiatry) and that they can become expert, or develop expertise, in their particular condition in a medical sense. Their experience drives a desire to learn more (Dumez and L’Espérance, 2024: 181). To admit of even this sort of medical knowledge that patients might have though, still should not be read as a conflation of it and knowledge possessed by a clinician. The dangers or problems this may give rise to were made evident by my slightly flippant surgery example in previous discussion. However, in thinking about the tentative explanation of expertise I gave above, we might say that patient knowledge could relate to the domain of their condition, and the impacts of that condition upon their relationships, livelihoods, personhood, and life, more broadly. This domain, then, Civan and Pratt (2007) argue is the domain of “being a patient”. For them, patient expertise refers to:

> “the experiential knowledge that patients have about effectively accomplishing the work of being a patient”

---

[57] Pols (2013) highlights the equivocation of biomedical knowledge, and patient knowledge, as being a primary issue in the acceptance of patient expertise, noting that those who argue for their equivalence elide important differences in content.

(2007: 140).

The idea that the authors propose, is that patients with chronic and enduring conditions, over time, amass a body of knowledge, derived from their experiences with the health system and, in managing their own conditions and their impacts. In time, as more knowledge is amassed, such patients progress along a continuum of novice-expert. This provides them not only with a thick epistemic advantage, and therefore renders them epistemically competent, in attesting to the experience of 'being a patient', but gives them an ability to speak to this knowledge. This may be especially true in discussions with others, newly diagnosed with that same condition (Civan and Pratt, 2007). The epistemic competence that patients have could be considered to give them a sort of epistemic authority over such newly diagnosed individuals. This is not only a strikingly similar description of patient expertise to that offered by Tekin (2023) and Dumez and L'Espérance (2024), but makes space for patient expertise which relates to more than the phenomenal aspects of having a particular condition. Dumez and L'Espérance's account of patient expertise, further argues that patients who are experts become an epistemic authority with respect to six distinct types of knowledge: embodied, monitoring, navigation, medical, relational, and cultural (2024: 179-182). Their epistemic authority, with respect to teaching other patients, Jamie Carlin Watson (2023) has called '*patient-facing-patient*' expertise. Such peer-directed epistemic authority I think largely uncontentious. If I have lived with a condition for longer than you might have, then it stands to reason that I may be able to tell you things about how I cope or manage with certain aspects, in ways that my experience has taught me, but which you may not yet know: I have a thick epistemic advantage, with respect to that condition.

5.2 – Expertise by experience revisited

To make the case, though, that patients should too be able to challenge traditional researchers in coproduced projects, establishing the possibility of patient facing patient expertise is insufficient. Instead, we need to get to a view of patient-facing-provider expertise (Watson, 2023). This, again, is not to diminish or to downplay the role of clinical expertise in any way, but is to make way for the view that patients may know more, and in some cases know better, than their clinicians. As Holman and Lorig (2004) note, patients who have taken part in self-management educational programs do seem to amass a body of knowledge which at least rivals the advice a clinician can give to them with respect to the 'how' of living with, or thriving with a particular condition or diagnosis (2004: 240). This too we could understand as them developing a thick epistemic advantage. Patients, with time, and with experience, can develop more epistemic competence than medical professionals when it comes to "social support and cohesion", "cultural norms" and the "material conditions" which surround their illness (Greenhalgh, 2009; Watson, 2023). This can, Watson argues, overlap, and occasionally encroach upon medical knowledge (Watson, 2023). This suggests, and I'm inclined to agree, that in some circumstances, patients may know to an equal degree, or perhaps even better than, their clinicians what the impacts of their condition, or even the exacerbating factors which affect their condition, are. There may be some technical aspects of pharmacology, or aetiology, and perhaps biomedical explanations, which a patient cannot lay equal claim to epistemic authority on, but the views here indicate that there are areas whereby patient knowledge could be considered competence, and where this competence might rightly be viewed as expertise. This, some argue, diminishes the role of provider authority in harmful ways (Nichols, 2017; Barnes and Bloor, 1982, Collins, 2014). And, it could, if one pursued the argument right to its logical conclusion, lead to conflation of self-education with medical-training (recall Goldman's argument around self tuition) which could serve to fundamentally undermine any medical authority at all. This, though, I want to say, is to extend a little too much scope to the notion of patient expertise: no one, I do not think, is actually claiming that admittance of patient expertise undermines the need for medical professionals. Stephen Tyreman (2005) is among those who have expressed scepticism with respect to the degree of epistemic authority we *should* afford patients, to avoid this end saying: "it is highly questionable whether they [patients] also become experts in their disease *per se*" (Tyreman, 2005: 155). Rather, Tyreman argues, we would do better to split the domain of 'the patient's condition' into two further sub-domains: (1) the scientific aspects of the patient's disease, and; (2) the patient's illness, understood as the lived elements of that disease (Tyreman, 2005). This, he presents as a *split-domain* view of expertise (Tyreman, 2005; Watson, 2023) which is to a degree, supported by empirical studies. For instance, Hartzler and Pratt found that:

> "sources of clinician expertise were predominantly medical in topic, knowledge-oriented in type, and prescriptive in style, whereas sources of patient expertise contained more personal topics that were carried through narrative-style action strategies and perspectives, these findings suggest that patients, by sharing their expertise about personal healh, meet an important information need unmet by clinical sources… Rather than filling the role of amateur doctors… the experiential knowledge offered by patients appears to focus on coping with highly personal issues drawn from the context of daily life"
>
> (Hartzler and Pratt, 2011: 19).

Patient knowledge, according to these authors, need not be factual, to be properly considered medical, but is not necessarily technical in its content (Kukla, 2007: 32). Tyreman himself, though, raises a potential issue with this split-domain type understanding of expertise, insofar as it retains historic and paternalistic views of the role of medicine, sidelining patient stories as anecdote (Tyreman, 2005). Such a retention could be understood as implying that patient views simply are not scientific. On Tyreman's original split-domain view then, ‘expertise by experience’ could be understand in the way I explained above as (d). As a reminder, this would be the view that ‘expertise by experience is a signifier for contributions which, though derived from lived experience, are to be treated as anecdotal, as opposed to scientific and factual’. Tyreman argues that such an understanding, particularly where we are dealing with “acute mental health issues” (2005: 156-7) is not a bad thing, and that perhaps paternalism in such scenarios ought to be preferred. To this point, I will return in chapter 5 of this thesis. For now, however, suffice it to say that Tyreman is not the only person to have raised a need to distinguish, or reserve, special epistemic authority in matters of a biomedical, medical, or otherwise scientific nature. Elizabeth Barnes (2023) writing about increased claims of ‘medical gaslighting’ considers the range of scenarios in which we should consider patients an epistemic authority on their own conditions. Barnes presents three sorts of claims that are prevalent in illness narratives. The first, what she calls a type (i) claim, focuses on experiences of suffering. Type (ii) claims relate to the seriousness or significance of that suffering, and type (iii) claims relate to the aetiology of suffering: in other words, the medical cause. Developing Katherine Hawley’s account of trust, Barnes argues that:

> “physicians should almost always trust patients about statements of type (i), almost never trust them about statements of type (iii), and that statements of type (ii) are a difficult middle ground”
>
> (Barnes, 2023: 13).

This could be taken as an indication of Barnes arguing that patients should not be considered either experts, or epistemic authorities about the causes of their own condition. Such matters, on her view, echoing Hartzler and Pratt, are best left to doctors. Barnes presents a range of examples in support of this claim, which indicate that proprioception and introspective analysis of one’s own body cannot give access to information about the objective condition of that body, however embodied our experiences and insight may be (2023). Here, there are several things to say. First, Barnes focuses almost exclusively on accounts where phenomenal experience is what patients are communicating as factual statements about their physiological state, and the leap from such felt*ness* to a judgement about the state of their body is what she is concerned with.[58] Whilst I agree that this sort of claim is not one any of us, even clinicians, can undertake with any degree of reliability (in the absence of previous experience), the arguments I have given above about the kinds of things patients may know are not restricted to the phenomenal. Thus, her arguments, whilst persuasive in relation to a fallacy in diagnostic knowledge derived from phenomenal experience, do not undermine the plausibility of expertise by experience, or even challenge to medical epistemic authority, which relates to others aspects of knowledge from experience. Second, Barnes' examples focus on physical, or at least not-mental ill health related, conditions. Even though some of her examples use conditions which cannot be verified objectively (by medical imaging, and laboratory tests, for example) such as fibromyalgia, and chronic fatigue syndrome, there are, in the case of physical medicine, verifiable means of determining whether one's heart is indeed functioning as it should. In mental ill health, whilst there is a wealth of clinical knowledge and expertise, there is no verifiable or objective test to determine whether one is 'well'. So, even though Barnes' arguments are undeniably successful in relation to physical health, where science can act as an arbiter on our behalf, I do not feel they are parallel to the case of expertise by experience, as I've discussed it thus far, in mental ill health.

---

[58] On reflection, I think the examples Barnes relies upon, such as feeling a pain in your hip, and so demanding you be taken seriously that your hip is broken when in fact you have damaged your knee, are not indications of a lack of epistemic authority had by patients at all. In matters of introspection and one's own bodily awareness, in this specific case, I think it possible that you can simply be wrong!

Such discussions may lead us to claim that there is no absolute fact-of-the-matter about where the bounds of patient expertise lie. Perhaps instead there are areas where clinician knowledge is more likely to be authoritative, and vice versa. Adopting such a view, Watson (2023) develops Tyreman's split-domain account of expertise, giving a *modified split-domain* view of expertise, based on the ways in which social meaning can influence health and the experience of being ill. Watson argues that the two domains we ought to consider are not, as Tyreman says, the science versus the embodied, but instead, the "lived experience of managing the LTC" and "the LTC as generalized across the patient population" (2023: 10). The former is the domain in which patients might be expert, the latter is reserved for those with clinical training. The content of these domains, Watson argues, overlaps in "non-trivial ways" (2023:10). The way that this makes room for shared expertise, which though properly called expertise, may differ in content, is as follows:

> "Skill and knowledge in patients' and providers' respective domains constitutes peer-like thick epistemic competence with respect to the range of topics and questions on which they overlap and thick epistemic advantage with respect to the range of topics where they do not… when both patient and provider are experts, there is substantial shared content that can include what have been traditionally identified as "objective," "subjective," and "social" aspects of conditions."
>
> (Watson, 2023: 10-11).

In one another's respective domain, outside of any areas of overlap, are thick epistemic advantages, lending themselves to expertise, which the other party does not share. This, given all we have seen in relation to the multitude of knowledges that patients may amass, and that clinicians surely possess, is intuitively appealing. Clinicians may be more medically competent, and well-versed in matters of research, and epidemiology, for example, but patients, because of their experiences, may understand to a greater degree, how to advocate for one's own care, how to navigate social stigma, and so on (Watson, 2023: 11). And it is perhaps the case, that a modified split-domain type view of expertise might alleviate some of the concerns that Tyreman, Barnes, and others who have voiced concern about the notion of expertise-by experience more broadly, have raised. For, a modified split-domain type view, makes room for medical expertise which is unrivalled, or perhaps not easily challenged, by patients, but which allows for the range of experiences patients have to 'count' as expertise in meaningful ways. We might wonder whether Watson's two 'domains' are quite right, insofar as they do not quite capture the range of knowledge that Dumez and L'Espérance (2024) argue patients possess.[59] However, the work here is not to give an account of patient expertise, rather, to argue for its possibility. Whether, and to what degree, such expertise encroaches, or might be said to encroach on medical or clinical knowledge, I leave open.

Something like the modified split-domain view of expertise though, building upon arguments in this chapter, to my mind make it incredibly plausible that expertise by experience is a concept we ought to take seriously, and ought to understand in the sense of (a) as set out in section 2. This understanding would mean that by using the phrase expert-by-experience, we are signifying a specific kind of expertise. Further, because the interest in expertise by experience here relates expertise which is unique or otherwise set apart from expertise possessed by academics and clinicians, there is then knowledge that experts by experience possess which, if they are excluded entirely from the research environment, we cannot utilise in knowledge production endeavours. Some of the content of both types of expertise will be similar, but it will likely differ in kind (Watson, 2023).[60]

---

[59] Castro, et. al (2018) argue along similar lines to Watson (2023) claiming that "(1) coping with one's own body and condition, (2) dealing with healthcare providers and their organisations, (3) handling social reactions, and (4) relating to peers" are key components of patient expertise, or expertise by experience (2018: 317).

[60] The temptation here is to argue that origin of the knowledge is what sets it apart, but on reflection, such a distinction would be doomed to fail. Experts by experience, as we've seen, may be keen to learn more about their mental ill health, thus enrolling in study or education to understand their condition, which would make their knowledge then rooted in education, not experience. Clinicians similarly may have the bulk of their

So, let us return to the way I described expertise at the end of section three, to see how we might now understand the concept, and whether it makes room for an understanding of expertise by experience in the sense of (a) (from section 2). I said earlier that:

Expertise relates to knowledge or skill one has, with respect to a particular topic, *t*, situated within a broader domain, *D*, such that one is reliably able to attest to matters relating to *t*, and possesses, by comparison, more justified beliefs about *t* than most people.

If we now consider then that individuals with lived experience have knowledge, with respect to topics, t^1-t^*, situated within a broader domain, *D*, and that they are reliably able to attest to matters relating to t^1-t^* and possess, by comparison, higher credences about those topics than most people, including clinicians, then we might say that they potentially have expertise by experience.[61] The broader domain, *D*, if you accept Watson's sort of modified split-domain view of expertise, may be the domain of the research context. Knowledge held only by the academics and clinicians within that context will be what sets apart their expertise. Of course, here I move away from justified belief, to high credences, to acknowledge that for many of the topics in question, there will be no fact or source to which we can appeal to evaluate justification. As such, high credence seems appropriate. On this view, individuals with lived experience of mental ill health could rightly be considered experts by experience. Expertise by experience, following Castro et al. (2018) we then might say, consists in being able to share one's knowledge in order to coproduce holistic interventions which have the aim of improving qualities of life and of care (Castro, 2018: 317). It is developed based upon one's embodied life, but it is developed nonetheless.

---

knowledge amassed from medical training, but their own experience as practitioners will no doubt have increased or enhanced such knowledge, over time.

[61] t^1-t^6 I use here to refer to those six areas of patient knowledge that Dumez and L'Espérance (2024) set out.

6 – Concluding remarks

This chapter then, has moved from the theoretical to the applied, insofar as I began with accounts of expertise offered by various theorists, illustrating the room in such accounts for experientially derived expertise. Such experientially derived knowledge, I have argued, is accepted by epistemologists without contention as it relates to the phenomenal. Extension beyond the phenomenal though, is required in order that we might be able to avoid claims that expertise by experience extends only to subjectively- known, and introspectively-felt, knowledge. Drawing upon recent discussions about expertise by experience, though, and ways in which others have argued for particular accounts of patient expertise, I have argued that there is reason to believe in, at minimum, the plausibility of expertise by experience as being a distinct kind of expertise. Expertise by experience may well be a broad range of topical knowledge, access to which, being a patient might grant and which duration and self-guided learning may further develop. Such expertise, I've discussed, may overlap with, but should be considered rightly distinct from knowledge that, in the context of coproduction, clinicians and academics will possess. Its distinctiveness, though, does not detract from its existence: there are grounds to believe that those with lived experience of mental ill health could be experts by experience. Failing to take them seriously without due consideration, then, could be epistemically short-sighted.

Summary of Part One

Part One, has explored whether we should take seriously the claim that not listening to individuals with lived experience constitutes an epistemic harm. This exploration, we might break into the following three questions, which Chapters 1 and 2 have answered:

(1) Where is the harm in coproduction?
(2) What is the role of knowing in assessments of epistemic (in)justice? And;
(3) Can patients possess expertise?

My discussion of (1) allows me to say that harmful aspects of coproduction, as they relate to patient testimony, are the diminishing, taking less seriously, subversion of, or otherwise interpreting in pathologising ways, the knowledge that patients offer. Or, as chapter one demonstrated is the case, in the dismissal of patient voice as merely anecdotal, and not making space for the knowledge it may contain in the broader research landscape.

Whether we would be right to consider such treatment of patient testimony an epistemic injustice, though, I argued in relation to (2) depends on whether the individuals whose testimony is not treated as knowledge, can indeed be considered knowledge. Arguing in line with Byskov's (2021) development of Fricker's (2007) original characterisation of epistemic injustice, I've then argued that in order to experience epistemic injustice, one must indeed *know*. Otherwise, I've claimed, dismissal of patient voice as shown in answer to (1) could be considered epistemic prudence on the part of academic or clinical members of the research team. This, I appreciate may be a contentious view, and should you be unpersuaded that the *epistemic condition* is required to show the potential of an epistemic injustice in any given context, you may find that setting the discussion aside in what follows will not detract from the applicability of arguments in Part Two.

Knowledge, I have argued, is possessed in degrees. Given that the context this thesis focuses upon is one where the academics and clinicians are considered experts in their fields, I selected to also explore (3). The rationale for this being that if patients possessed something which could be considered knowledge, but which did not meet the threshold for expertise, then dismissal of their voice, as in (1) could easily be answered as deference to professional expertise: experts just would know better in the cases at hand. In arguing that we can answer (3) affirmatively, I've claimed that the concept of patient expertise is plausible. Its derivation from experience need not lead us to the claim that it is entirely phenomenal in content. Demonstrating that Watson's (2023) understanding of patient expertise closely tracks discussions of expertise by experience (Castor et al. 2018; Dumez and L'Espérance (2024), I've explicated that expertise by experience may well differ from professional expertise, but may, in some areas, overlap with it. What this shows then, is that in some cases, individuals with lived experience, who henceforth in this thesis I refer to as *experts by experience*, will know *better* than their academic or clinical counterparts.

This does not resolve questions around the conditions which would need to be met to say with an element of surety that this *particular* expert by experience, in any given research project, has such expertise. Regrettably, such conditions for assigning expertise fall outside of the scope of present work. However, in arguing for the plausibility of expertise by experience, what I hope to have shown, is that we should take patients seriously. Systemic bias in mental ill health may well easily explain the undermining of expert by experience credibility, but the picture may be more complex than mere stigma. The upshot of this, is that it may well be apt to consider the exclusion of expert by experience knowledge as a sort of epistemic injustice. The sensible next question, which I address in Part Two, then, is *which* view of epistemic injustice is best placed to explain these kinds of epistemic harms.

Part Two: ***Epistemic injustice – diagnosing the epistemic harm***

Chapter Three: **Candidate theories of epistemic injustice**[62]

1 – Introduction

I've claimed that *expertise by experience* when related to mental ill health, is a useful concept, and one which elucidates the unique insights possessed by those with lived experience of mental ill health. Whilst I have claimed this does not rival medical or academic qualification in all respects, when joined with these kinds of expertise, as in coproduced research, the inclusion of experts by experience might get us a better, and more widely applicable, holistically considered, view of research foci.

However, I have also outlined just some of the ways which expert by experience testimony is not taken seriously, or is otherwise undermined (see ch.1, 3.1.). In the summary of part one of this thesis, I argue that this could well be considered an epistemic injustice, owing to the aforementioned knowledge that experts by experience possess. This claim – as with many claims relating to epistemic injustice more generally – is not, I appreciate, an especially novel one. Since Fricker's (2007) work has become something of a *locus classicus*, there have been thousands of discussions of epistemic injustice, with many differing applications of the central thesis having been used to explain the harm in a range of real-life contexts. Medicine, and mental ill health, are no exception to this. And as such, you would be forgiven for not thinking that an exploration of epistemic injustice here would yield especially interesting insight. On this, I hope to show there is yet more that we can say.

---

[62] Parts of this chapter contain arguments similar to those I presented in '*Co-Production and Structural Oppression in Mental Health'* (Wilde, 2023), particularly the discussion of Fricker's testimonial injustice in section 2.

Epistemic injustice, it is imperative to be clear, is not itself a theory. It is, rather, a phenomenon relating to “unfair treatment [relating to] issues of knowledge, understanding and participation in communicative practices” (Kidd, Medina and Pohlhaus Jr, 2017: 1). And how this unfair treatment may work, mechanistically, has been cashed out in various ways. Broadly painting some practice as an epistemic injustice, then, hardly suffices to pinpoint the precise nature of that harm, or to understand how we might appropriately redress it. As such, I’m going to explore a range of different accounts of epistemic injustice to see how we might best understand the harms perpetuated in the cases of coproduction that I consider. These accounts relate are: (i) *testimonial injustice*, (ii) *epistemic objectification*, (iii) *epistemic othering,* (iv) *hermeneutical injustice*, (v) *hermeneutical impasses*, or, (vi) *contributory injustice*.

Most of these views, I’ll argue, could plausibly explain elements of what is happening in the cases I consider, or at least will allow us to make sense of the harm in intuition tracking ways. Despite that, I’ll argue that all fail in some way or other to capture important aspects of the harms that I think coproduction is (often inadvertently) perpetuating when it fails to allow space for expert by experience knowledge.

2 – What ‘counts’ as an epistemic injustice?

Typically, when theorists discuss locutionary practices, we assume that there are a minimum of two parties present: a speaker, and an audience, hearer, or inquirer. Communicative interactions can be at the level of a conversation between friends, or can be in bigger and broader conversational arenas, where the audience may be large in size. If all goes well, then whatever statement, *P*, is offered by speaker, *S*, is taken as true, and the audience come to also believe either that-*P*, or at least that *S* thinks that-*P*.[63] As anyone who has had even a limited number of conversations knows, though, getting across one's point, unchallenged, is not always so simple. *P* may be misheard, or not heard at all – especially if my audience is distracted – or, *P* may be challenged, because my interlocutor may believe that not-*P* is true. And so, there are many ways, even in straightforward communication where my intention to tell someone something is clear, their intention to believe my assertion is not false, and yet, I fail to communicate that *P*. Utterances quite often are not received in the ways we hope. Are these injustices? I'm inclined to say not. Not being heard (in a plain-English as opposed to a speech-act theory sense of the phrase) or having my opinion disagreed with do not, by themselves constitute epistemic injustices, however annoying they may be. These are, *ceteris paribus*, innocuous communicative mishaps. Routinely ignoring my interlocutors might make me a poor conversational partner, or may indicate I do not abide by the norms of communication, but in isolation they are mostly harmless.[64] To be an *epistemic injustice*, as I've argued in Part One, my ability to convey knowledge and to be treated as a competent knower must be undermined on the basis of my facing stereotypical judgements about the likelihood of me speaking credibly. Being misheard, alone, does not constitute such an undermining.

---

[63] As I'll come on to discuss, this is the case where the intent of the audience is to believe, or to learn from S. As Harcourt (2021) notes, this is not always the goal of communication, however, and so belief-in a proposition that *S* has shared with us, may be only one of a number of potential plausible outcomes of communication. The point here, is unaffected, however, as it is merely illustrative of what happens when credence is not at issue.

[64] There are undoubtably instances whereby patterns of such behaviour could be argued to constitute an epistemic injustice, though I suspect other features (e.g. gender, power, identity, or misguided preconception) are required to make such arguments. I say this as I consider there to be very relevant differences between being routinely ignored by my four year-old nephew when asking her to put away toys before dinner, and being routinely ignored at work by male superiors when conveying my professional appraisal of a situation. In the first scenario, though there is a pattern in my failure to be heard in the way I intend (i.e. by inspiring action on my niece's part), she simply does not want to do as she is told, and I suspect, hears me very well. In the second example, though, a multitude of factors are likely at play – I am a junior, female, colleague, and my experience could be ignored in the context of any of those factors. The second case *may* constitute an epistemic injustice, but it would require further consideration, and should not automatically be considered to be so.

In other cases, my assertion that *P*, may be heard and received by my audience, but because of some important (to the audience) aspect of my positionality, which is salient in the context of my credibility, *P* is not accepted as a credulous statement. This can particularly be the case where my interlocutor considers themselves to have *epistemic superiority*, which leads them to believe that they know better than I whether *P*.[65] This notion of identity, as I began to consider in chapter one, is central to the concept of epistemic injustice. However, beliefs relating to someone on the basis of their identity alone does not get us to an understanding of epistemic injustice, either. Why, you may wonder? Consider an interaction with a child – my four year-old nephew, perhaps. If I, as an adult, afford equal credibility to my nephew in interactions, a whole host of things could go wrong. This is not to say I should never believe his assertions, but our epistemic position is not equal, in virtue of the fact that he is a child, and I, an adult. If I ask him where my car keys have gone, them previously having been on the table, and he tells me "a big dinosaur ate them", my belief that what he literally says is not true because I know it to be an impossibility in 2025 that dinosaurs are wandering around dining rooms, is not an epistemic injustice. This is the case, in this context, even though his age means I assign him less credibility. This, is what Fricker (2007) refers to as assigning a *credibility deficit*. Credibility between two conversational partners could be seen as something of a zero-sum enterprise, insofar as deflating my nephew's credibility automatically means I inflate my own (for Fricker, a '*credibility excess*').[66] In a truly equal conversation, each conversant might be assigned equal credibility, giving each equal power to assert, and to be believed. In my

---

[65] In Part One I discussed the concept of epistemic authority. Epistemic superiority might be understood as assigning oneself an inflated level of such authority.

[66] Understanding credibility in this manner raises questions regarding the distributive nature of credibility as a 'good'. I briefly explain why I am not sympathetic to distributive injustices based upon this, especially in relation to the cases I am considering, in fn 75 and also in Chapter 4.

interaction with my nephew, who I have reason to suppose knows *exactly* where my keys are, by deflating his credibility, I make assumptions about my own.[67]

Credibility deficits, and indeed excesses, are commonplace, as this shows. We quite often afford more credence to the testimony of some speakers than others, and consider particular individuals more or less able to give us reliable information. And sometimes, as I argued in chapter one, in line with Byskov (2021), this can be right.[68] Determining that someone does not *know* in ways that should require us to take them seriously, though, need not always be as robust as the arguments given thus far for expert by experience knowledge. And often such determinations will not be this robust. I do not conduct a conceptual analysis to determine that my nephew is not an expert on the matter of key locations (if one could ever be considered an expert in such a domain), rather I make a snap judgement that he should not be taken as a credible knower in this case. Deflating credibility when assumptions have been made about a lack of knowledge possessed by an individual, can, as I've argued, be epistemically prudent.

In the kind of example, I gave in chapter one, though, whereby I assign a credibility deficit to my QAnon reading colleague, whose views strike me as conspiratorial in nature, the question of whether my judgement is morally pernicious, is complex. In making a judgement about QAnon readers, I do rely on both a prejudice, and also a stereotype, in deflating their credibility. It's perhaps even possible that in assigning them a credibility deficit, they feel as

---

[67] This could be disputed, insofar as it may be *prima facie* possible to disbelieve someone without believing yourself to have higher credence in a view to the contrary. However, I'm receptive to the position I set out here, in that disbelieving anyone appears to require that I make a judgement that I'm better placed than them to determine if they are indeed correct. And so, whether disbelief without inflation of someone's credibility, strikes me as somewhat implausible.

[68] Coady (2017) also asserts that to deem someone credible, we ought to have reason to believe they know something of importance to the situation, which, similarly to my example of my QAnon reading colleague, rules out many conspiracy theorists.

though I have harmed them as a knower, in a manner which I do not harm my nephew when he tries to convince me that my keys have become a dinosaur's appetiser. And, perhaps I do. My reduction of the credibility of my QAnon reading workmate is, in a not insignificant way, a refusal to acknowledge the possibility that (what they believe to be) their justified belief is an apt or right appraisal of how health works. I do not afford them the status of 'knower' in this situation, though in others I may well believe them. But, following Byskov's (2021) discussion of the epistemic condition which must be satisfied to say an epistemic injustice has occurred, I do not believe there is knowledge which I prevent from being added to the conversational score. Making this judgement, though is largely rooted in prejudicial beliefs about the class of people who read QAnon seriously.

2.1 – Ethically poisonous, affectively bad, investments: taking speakers seriously

Such judgements and prejudicial beliefs often arise on the basis of stereotypes. And, stereotypes upon which I rely in making credibility assignments can be positively or negatively valenced.[69] I might, for instance, believe all academics to be intellectually superior to the general population, or, as just discussed, QAnon readers to be poor authorities on political matters. Stereotypes, Beeghly (2015) says, function as shortcuts in our cognitive processes, which are recalcitrant to counterevidence (Beeghly,2015; Zhang et al., 2022). They allow us to rapidly appraise individuals on grounds such as credibility, reliability, likelihood of truth-telling, and so on (Fricker, 2007).

Epistemic injustice *qua* testimonial injustice, at the level of interlocutions, depends upon my deflating the credibility of one conversant party, such that I disbelieve, or discount their

---

[69] Blum (2004) argues against this, claiming that all stereotypes are negative or prejudicial.

view, unjustly. In order to be an injustice though, this downgrading of credence must be based upon my utilisation of a stereotype which is pernicious, prejudicial, or otherwise ethically poisonous (Fricker, 2007: 22). This allows me to determine whether I take the conversant party seriously, or not. The question of whether my judgement constitutes testimonial injustice, for Fricker, hinges on the question of whether the stereotype itself is harmful.[70] She says:

> "the [ethical] poison of testimonial injustice must derive from some sort of ethical posion in the judgement of the hearer and there is non such wherever the hearer's error is ethically non-culpable… ethical poison is one of prejudice"
>
> (Fricker, 2007: 22).[71]

Prejudicial stereotypes, Fricker then explains, are one in which we have placed ethically bad, affective investment: we are bought in, or influenced by these in the social or political realm. Fricker's own explanation of *testimonial injustice* draws on the courtroom depiction of Tom Robinson in Harper Lee's *To Kill a Mockingbird*. Despite Robinson not having committed the rape for which he is ultimately charged, the jury find themselves unable to extricate what he says, from the pernicious stereotypes circulating in 1930s Alabama, relating to Black men and proclivities toward violence. Such stereotypes are not only prejudicial, they are in fact wrong. As such, a testimonial injustice takes place. Robinson is perceived to be lying by the jurors, and nothing he says in an attempt to persuade them of his innocence is able to surmount the deficit in his credibility that the jurors assign. In Harper Lee's work, the white, female, complainant, Mayella Ewell, in virtue of her being white, is automatically assigned a

---

[70] Here, one could question whether there might be a counter-argument that even a positively valenced stereotype (for instance, my example that academics are all intellectually gifted) could give rise to an epistemic injustice insofar as it could lead to my *inflation* of my interlocutor's credibility, at the expense of another. In this kind of case I would still deny the individual whose credibility I diminish in their capacity as a knower, but the stereotype in question would not, indeed, relate to them, nor would it be ethically poisonous. This, though interesting, is a counter-example to Fricker's characterisation, and is not a matter which has bearing on present work.

[71] I appreciate that my fictional interlocutor may well feel as though I rely on an ethically poisonous stereotype. There is much that could be said regarding this, though it falls outside of the scope of present work.

higher credence. The racist – and so both morally pernicious *and* erroneous – heuristics which underlie the jurors' credibility assignments is what makes this *the* central case of testimonial injustice. Whether or not I *should* believe the interlocutor whom I dismiss, and whether my decision to disbelieve them is rooted in an ethically bad affective investment I have made, matters.

In my QAnon example, I argue that this means I do not commit a *testimonial injustice* for two reasons. First, as I've already stated, I do not believe he *knows* information that I should believe in the context I described. And, whilst I do deflate my colleague's credibility, and I do so on the basis of a stereotype, I do not consider the affective investment I have made in the negative views I hold of QAnon readers ethically bad, or, perhaps better, epistemically bad. It is possible that the stereotype in this case is prejudicial – it certainly is not positive – but empirically, thinking back to epistemically continent agents, as far as I have reason to believe, I am justified in my belief that QAnon readers are more likely than not to espouse conspiracy theories. My appraisal then, I believe, demonstrates to some degree, epistemic competence. We should not believe everybody, and in fact, often have good reason for not doing so.[72]

As discussed in chapter two, however, these 'good reasons' can themselves be more or less justified. Power, especially that which is bound up with ones' identity or social positionality, is an integral factor in the justifications we give to deflationary attitudes to others' credibility. This power features insofar as the victims of testimonial injustices typically belong to historically or socially marginalised groups. The individuals in such groups do not operate in

---

[72] I admit the implications of this statement are challenging to parse. When working with what we consider to be subjectively justified true-beliefs, this view could absolutely extend to a range of morally problematic contexts.

a context where they are taken at their word, or appraised as credible and equal knowers (and in some cases, citizens). Kidd and Carel (2017) explain this as follows:

> "A typical case of testimonial injustice could involve negative stereotypes of a particular race or gender as suffering inferior cognitive capacity and a presumed predilection for deception, such that their epistemic credibility is automatically downgraded"
> (Kidd and Carel, 2017: 177).

There may be anomalous cases whereby, pace Byskov, a member of a dominant social group is subject to testimonial injustice, but I think these reasonably rare. This, I argue, is because typically the ability to assign credibility or to act as an arbiter or who is right or warrants credence, is restricted to those in positions of more power to begin with. This is not to say that the most powerful are distributing credibility, as I will come on to discuss in chapter 4, but is to reflect that marginalised individuals typically have less ability to shift conversational norms, or, as I'll also say in what follows, to create epistemic disturbance in harmonious epistemological systems. With respect to what one can, or cannot, assert, the unspoken rules which depend upon permissibility of such assertions in conversation, are often not controlled by those in the out-group (Austin, 1962; McGowan, 2009).

To explore further, let us return to the interactions between patients and clinicians in health care. I considered previously whether patients, or those who have experienced ill health, *should* be treated as experts in their own circumstances, and concluded that in some cases, the answer is yes. However, as we saw Barnes (2023) argue, this is not ubiquitously true: we probably should not believe patients, whose laboratory results are unremarkable, when they tell us that their mysterious collection of unverifiable symptoms are indicative of an incredibly rare illness (Barnes, 2023).[73] And, in diagnostic contexts, as Edward Harcourt

---

[73] This of course should be the case iff that condition would be expected to cause issues with those laboratory results.

has argued (2021), we might rightly question whether the aim of interaction is ‘belief’ at all. Sometimes, it might be appropriate to rely on patient testimony only insofar as it guides a diagnostic appraisal (Harcourt, 2021: 734). The purposes for which we undertake communication differ, and sometimes, I might ask a question of you to gauge your mood (by for example, interpreting the tone of your response), or to assess how aware you might be of your surrounding and immediate context (Harcourt, 2021). I’m not asking these questions because I need to *believe* the answer, rather, I’m using your testimony as a sort of barometer for whatever it is that I’m trying to evaluate. So, even in healthcare settings, there are plausibly instances whereby I do not believe a patients’ testimony, or even assign it a high credence, because belief or credence is not what is at issue. In such cases, I do not go so far as to commit a testimonial injustice, as my disbelief is not grounded in prejudice: *believing* what you say was never my aim.[74]

Being ‘ill’ though, Kidd and Carel (2014, 2017) note, means individuals are often subject to stereotypical aspersions, almost always negative, which deflate their competence (or credibility) as knowers.[75] These, the authors refer to (2017: 178) as ‘moaner’ or ‘drama queen’ stereotypes, or as being otherwise traceable to perceived relations between illness, cognitive impairment, emotional distress, and reliability or rationality (Kidd and Carel, 2017).

---

[74] As we will see when I come to explore *epistemic* objectification, not intending to believe a patient, and instead viewing them as a source of information for our own purposes, has too been cast as a harm in an epistemic sense. Whether this might be an explanation we could appeal to for exclusion of expert by experience voices, I return to later in the chapter.

[75] David Coady (2012a, 2012b, 2017) has argued extensively that such credibility deflations are indications of not testimonial injustice, but injustice in the ways that credibility is distributed amongst groups. There are a wealth of things to say about this, and regrettably I do not have space to have such discussions here, but the central issue with credibility distributions on my view is that they indicate credibility is finite. As I’ve illustrated in my discussions of patient expertise, I think there’s good reason to assume that credibility both is not finite, in the sense that it can and should be had to various degree depending upon the context we are in, and that it should not be held equally by all. Whilst coproduction ought to require parity of credibility at its core, I remain sceptical that this demands equal credibility on all matters. Rather, *pace* Coady, I am of the view that credibility should be granted in accordance with the evidence, and I suspect it is the bases of this evidence that give rise to issue. This, I discuss further in Ch4. S3.2.

What is especially perplexing about the testimony of patients in the context of ill health (both physical and mental in nature) is that we are largely depend on it, to begin our clinical investigations. Kidd and Carel note that:

> "patient testimonies are sought as sources of factual information, but testimony about the lived experience of illness and the clinical encounter, which may challenge the medical view, is often excluded from decision making"
>
> (Kidd and Carel, 2017: 179).

We might, question, following Harcourt's point about the intention underlying interactions, the use of 'factual' in the quote above, arguing that it belies clinicians' aims in seeking patient testimony about their phenomenological experiences. It is, of course true that oftentimes, such testimony is the best we have in terms of determining our best course of action, but I think it false to assert that we seek to, or even should, thus treat it as a source of fact. Rather, the purpose of clinical expertise is to interpret such testimony in a way which determines appropriate diagnosis and treatment, at least in clinical interaction. This, of course, is a thorny issue. As Kidd and Carel rightly note, negative identity-prejudices are rife in the context of illness; arguably more so in relation to mental ill health (Kidd and Carel, 2017; Crichton, Carel and Kidd, 2017)[76]. Richard Lakeman (2010) illustrates this well, noting that in his time as a doctor, he was able to relay surprising observation without question, but once a patient himself, that changed:

> "I recall feeling profoundly affected by a small dose of a commonly prescribed psychotropic drug. When I reported this to the prescriber, my claims were met with incredulity, as the reaction I experienced was quite unusual. As a profession, the veracity of my reporting of the symptoms or behaviour of others had never been called into question in the manner that it was when I was in the position of patient"
>
> (Lakeman, 2010: 151).

---

[76] See also Newbigging and Ridley (2018).

It is, however, incontrovertible that physicians have historically had, and perhaps still have, more power than patients (recall, this was a discussion touched upon in chapter one), and such power asymmetry could help us to make sense of why Lakeman encountered greater difficulty in establishing his credibility as patient, than as clinician. In mental ill health in particular, as I've noted, the power psychiatric clinicians have is arguably of a different sort to in physical health, due to the potential for forced, or ordered, treatment or detention. There is, too, a wealth of evidence which indicates that marginalised, or vilified social groups, such as Black men, have far more likelihood of having legislation like the *Mental Health Act* utilised to detain them. Thus, the degree to which patients are viewed as speaking credibly, or are seen to be providing reliable and reasoned summaries of their experiences, may well depend on other identity-prejudices that they may be subject to i.e. their gender, ethnicity, or socioeconomic status.[77][78] Often, the very real and established biases that are directed towards ill persons then, irrespective of other characteristics they may have, has led to patient dismissal being understood or construed as a kind of testimonial injustice (see Carel and Gyorrfy, 2014; Carel and Kidd, 2014; Kidd and Carel, 2017; Chrichton, Carel and Kidd, 2017; Sanati and Kyrastous, 2015). This has also been the case where retrospective assessment of the use of patient narrative has been analysed, with writers claiming that apparent evidence of testimonial injustices can be found even when a patient is not presently communicating (Sontag, 2009). This may be because, as Kidd and Carel (I think, rightly) elucidate:

---

[77] This may well function based solely on what 'categories' individuals are presumed to belong to. For further discussion of presumptive social identities, and associated stereotypes and negative treatment, see especially Ásta (2018).

[78] This is, of course, what Crenshaw (1991, 2017) refers to as intersectionality, as the compounded bias or discrimination one faces, when one is a member of multiple marginalised groups.

> "ill persons are… demonstrably vulnerable to testimonial injustice because entrenched features of the social and medical world incorporate a variety of negative stereotypes of ill persons that sustain prejudices that impose credibility deficits" (2017: 178).

In clinical interactions, though I've indicated some concern with respect to the notion of 'belief' as the sole aim of discussions, I do not doubt that negative stereotypes can, and do, determine whether patients are able to have themselves heard, in a broad sense. This, I do not intend to signify 'be believed', but instead I mean instances whereby a patient recounting the distress they feel may be dismissed as being 'dramatic', or as experiencing something which is judged to have little clinical significance. These instances might still be ones of testimonial injustice, insofar as they likely involve the same kinds of credibility deficits, rooted in social misperceptions about particular groups.[79] Similarly, in mental ill health, I think it perfectly plausible that there *are* instances whereby a patient, already diagnosed with a mental ill health condition, attempts to communicate something truthful to clinicians and has that (truthful) assertion written off as grandiose or delusional, on the basis of stereotypes surrounding their illness and incredulity that what they assert could possibly be true. Such instances are discussed by Sanati and Kyratsous (2015),[80] Thorne et al. (2000), and Guidry-Grimes and Watson (2021). Such cases, Harcourt has argued, might be instances of testimonial injustice not on the basis of deflation of patient credibility, but of *expert arrogance* (2021: 730-33) which allows clinicians to assure themselves that they

---

[79] The example which immediately springs to mind here is women, dismissed as 'hysterical' or dramatic, despite it transpiring that there was an explanation for their symptoms which doctors failed to explore as a result of their bias. This has been termed 'medical misogyny' by some. See, for example, Ritchie (2024).

[80] The authors of this paper (2015) argue that reliance on prejudicial stereotypes surrounding psychiatric illness cause run-on dismissal of delusional patients on matters which, it later transpires, they are knowledgeable and truthful. I'm sympathetic to Harcourt's (2021) concerns about the cases Sanati and Kyratsous consider as mistakenly supposing that believing the patient is what's at stake, and their conclusions with respect to testimonial injustice. My use of this paper here is though, is to demonstrate that once a patient is even assumed to be unwell in the sense of a mental ill health concern, even their true assertions are primed for disbelief.

surely know best, and since the assertion they are presented with pertains to something they deem improbable, they would do best to disbelieve it. Harcourt thus seeks to expand the range of instances, or perhaps better the kinds of explanations we might give, of testimonial injustice, which can occur without reliance on negative stereotype. This is intuitively appealing, as in these instances, we're talking about groups of clinicians who should know better than to fall foul of such stereotypes. That said, I won't defend Harcourt's view further here. Epistemic arrogance, though is not to say that clinicians are absolved of predilection to rely upon stereotypes, or even to hold negative-affective stances towards particular patients, with particular mental ill health concerns, thus predisposing them perhaps to treat the testimony of some with heightened scepticism.[81] All of this to say then, that testimonial injustice may well accommodate some instances where patients are disbelieved and discredited. A tendency to understand any and all instances of patient dismissal as a sort of testimonial injustice, though, as Harcourt notes, has served to dilute the utility of the concept somewhat. This, as I set out, is why in part one I sought to show that some patients should rightly be called experts by experience. Whether we might then determine that testimonial injustice suffices to explain the exclusion of expert by experience voice, as set out in Ch.1 3.1., I will now move on to explore.

2.2 – Coproduction: rife with testimonial injustice?

As I've construed it then, epistemic injustice which is testimonial in nature relies upon the credibility of a speaker being downgraded due to prejudicial stereotypes, resulting in lesser degrees of belief or confidence afforded to that speaker than to myself, or another

---

[81] I'm thinking especially here of personality disorders. For more on psychiatrist's perception of patients diagnosed with a personality disorder see: Lewis et al. (1988), Chartonas et al. (2017) and Dudas (2014).

conversant party. And, as I've highlighted, there are a wealth of examples of mental ill health being linked to negative stereotypes which cast aspersions on one's reliability, rationality, truthfulness and tendency to exaggerate. Thus, the question becomes: does testimonial injustice tell us all we need to know when it comes to coproduction and the exclusion of experts by experience? The short answer is yes, it very well might.

The mechanisms outlined by Fricker (2007) suffice perfectly satisfactorily to give us a plausible explanation of how experts by experience, in virtue of being the subject of negative stereotype may have their credibility downgraded, such that their contributions are devalued, disbelieved, or are otherwise powerless to affect shifts in group thinking. If we are interested in how an individual knower *qua* epistemic agent, might be harmed in an epistemic sense, then appealing to faulty heuristics as the basis for credibility deflation may do just fine at explaining the harm in play. Harcourt's (2021) claim that in some cases, the faulty heuristic is not a stereotype at all, but is some sort of self-ascribed superiority to *know better* fits just as well here, if one is concerned that an argument which uses Fricker's original construal of epistemic harm implicates clinicians as worryingly biased against those they are supposed to treat.

However, in thinking about coproduction and expertise by experience, it is important to hold salient that oftentimes, the goal is not to be taken as credible or expert in every sense, but to have one's knowledge have the potential to shape shared epistemic resources. In that research context, we are not only focused at the level of individual interaction, but upon patterns of exclusion of voices that were invited to the metaphorical (or perhaps literal) table. The academic or clinical experts around said table, have, presumably, committed to coproduce the research project, they have invited experts by experience to be a part of. This means that they have also committed to actively work to centre the voices of those with lived experience. And if we're satisfied that testimonial injustice tells us all we need to know, then clearly something is going awry and members of the academic/clinical community are undertaking coproduced research in bad faith.

This isn't what I think is going on in such instances. And if it is not, then there must be some other explanation for the routine and perpetual exclusion of marginalised voices. We could argue that this is no more than a series of epistemic transgressions, or even multiple and repeated testimonial injustices, though I don't think that this quite gets at what is required. Not being believed or taken seriously as an expert by experience is no doubt jarring, but as with Harcourt's issue with Sanati and Kyrastous's (2015) work, I do not think the goal of experts by experience in coproduction is to be believed. Rather, I suspect it is to advance, and contribute to the advancement of, knowledge and to have one's view thus affect epistemological resources. In order that research be done effectively and result in progress relating to what we take ourselves to understand, or to do, there are norms, conventions, and broader requirements at play such that knowledge gains uptake and might enter into shared understanding. These I will come on to in more detail in chapter four.

For now, suffice it to say that if your interest is at the level of individual interaction, then testimonial injustice does, I think, capture what's at stake fairly well, especially if Harcourt's expanded genus were developed further to allow for credibility deflations on the basis of things other than stereotypes, which too were unjust or untrue. However, I think the view it gets us to is quite narrow, and commits us to an implication that in an optimal coproduced project, equal credence would lead to all knowledge being received as a candidate explanation or theory. This too I think, misrepresents coproduction, which leads us right back to the discussion about the purpose of testimony. I want to argue that it is *not*, or rather should not be the point of inclusion of experts by experience that their testimony is believed or taken to indicate truth, per se. Rather, in taking part in a project as a research partner, sometimes a discussion ensues in which not everyone can be right – perhaps being 'right' is not even the point – but where cumulative contributions allow a bigger picture to emerge. And in this instance, whilst we could appeal to Harcourt's addition of expert arrogance as the reason for the dilution of expert by experience contributions to that bigger picture, this would still commit us to some morally pernicious conduct on the part of clinicians or academics whose credibility has been adjusted to privilege their own views. If you are satisfied with this conclusion, then testimonial injustice may possess satisfactory explanatory power for your purposes. However, I am less than convinced that expert arrogance is (at least always) the cause of dilution of testimony in such ways, and thus I think we could do better by looking elsewhere.

3 – Mis-sold? Coproduction under the guise of equal participation

Perhaps, we might think, the issue with coproduction is that experts-by-experience, despite being named as such, are not treated as experts or as equals, but are instead viewed as sources of information[82]. Stereotypes and biases aside, if I view someone as a source of information, or I do not seek their views for their views' sake, but instead seek to inform my own investigations, then this could be harmful all the same, though differently so.

A criticism that I touched upon in 2.2. of some clinical interactions where the aim of communicative practice is not to be believed, or to be established as 'right' is that in such encounters, we have in some significant sense, objectified the patient with whom we are talking. This is especially true if the patient expects, or has been otherwise led to believe,

---

[82] This could be understood as being a type (d) understanding of expertise by experience, based on the range of options given in Chapter 2.

that our intention is to believe them. But, as I noted above, and as Fricker agrees, sometimes this treating of a patient as a sort of state of affairs from which to glean important and telling information, without necessarily viewing them as a conversant equal (in context) is necessary (Fricker, 2007 p.132). The context of the interaction is what determines whether an instance of epistemic objectification is harmful, or morally questionable (Fricker, 2007: 271; Nussbaum, 2006). I've argued that in some patient encounters, it is imperative that the patient is not taken as truth-telling, or at least that my believing that the patient is truth-telling about factual events in the objective world is not the primary goal of communication. This is especially the case where a patient might be agitated, experiencing psychosis or other delusion, and might have fears or paranoia which, though incredibly real *to the patient* are not accurate depictions of reality (Harcourt, 2021).

Fricker claims that epistemic injustice – and so testimonial injustice, since that is what she is discussing – just is to treat an individual as a state of affairs, as opposed to an individual with their own epistemic agency (p.132; McGlynn, 2019: 164). Treating of an individual as an object, rather than an inquiring subject, whether or not you are inclined to think that this is the primary harm of epistemic injustice, has invited much debate. Aidan McGlynn (2019) for instance, has argued that it is perfectly viable for one to rely upon a stereotype to downgrade an individuals' credibility without casting any aspersion as to their status of epistemic agent: I don't treat them as a state of affairs, as I might in the case of epistemic objectification, I simply disbelieve what they are saying. In this sense, McGlynn argues, my affording of more credibility to another does undermine a speaker in their capacity as a knower (and in the case Fricker considers of Tom Robinson, does so on the basis of a faulty heuristic aid), but this doesn't require that I view them as lacking capacity for knowledge, simpliciter, nor entails a downgrading of them to 'passive subject of inquiry' (2019: 167). You need not even take a view about whether epistemic objectification is, or is not, the primary, or intrinsic, harm of epistemic injustice to consider it as a phenomenon in its own right.[83] Nor, I think, need you make any sort of judgement regarding an individual's epistemic agency to epistemically objectify them – thinking back to my earlier examples, I may very well use a patient's overall demeanour, content of their testimony, and pitch/tone of their responses to determine whether they are experiencing delusion, thus treating their presentation as a state of affairs, without undermining their epistemic agency, since my intent is not in any way related to what they 'know': my goal, or project, in such cases is not to recognise their epistemic agency. This, of course, is an instance whereby Harcourt (2021), and I suspect Fricker, if presented with the case, would claim that treating the patient as a state of affairs for *this* practice is not harmful, since it is in their interests (over the longer-term), but that this does not mean we ought to treat all patients as such.[84]

In coproduction though, we do not always see instances whereby individuals are both deemed credible *and* disbelieved; rather the cases I have demonstrated in Chapter 1 (s3.1.) of this thesis indicate that often there are manifest means of narrative subversion or distortion at play.[85] Even those experts by experience who do not report feeling as though bias was working against them, but who have perhaps contributed views which challenge widely accepted norms (such as those which privilege a sense of psychiatric normalcy) have

---

[83] As Papadaki (2024) notes, and as Haslanger (2017) echoes, we use 'objectification' in many different ways to denote differing phenomena. Here I take it to mean objectification in the Kantian sense of treating an individual as a means to some end, rather than as an end in themselves.

[84] In fact, moving from what *is* in one instance, to a normatively prescribed 'ought' would contravene Hume's law.

[85] By 'credible and disbelieved' here, I mean to indicate that often there is a question mark around a patient's credibility which underlies disbelief in what they say, i.e. on the basis of some stereotype or other. There will of course be cases where what a patient or expert by experience says does not make it into publications, or does not manage to affect shifts in overarching research findings, but these, much like many other facets of the scenarios I am considering, can be innocuous and part of normal research practice, again depending on context.

experienced their views not ‘counting’, without feeling disbelieved or ignored. And, we can’t say, I don’t think, that in these instances, there is a parallel with the clinical case above, whereby treating the individuals as a state of affairs is warranted, because the very aim of coproduction is to jointly engage in communicative practice. At best then, if we were to attempt to run the argument for epistemic objectification in attempt to explain the ways that experts by experience testimony is not treated as knowledge, the best odds of success might come from claiming they have been treated as informants, and not, as coproduction requires, as co-enquirers. Articulating the claim in this way, as Jose Medina (2012) explains, would allow us to say that experts by experience can take part in some sense, but not to a truly meaningful degree:

> “when one is allowed to be an informant *without* being allowed to be an inquirer, one is allowed to enter into a set of communicative activities – those related to passing knowledge and opinions – but not others, precisely those that are more sophisticated, happen at higher levels of abstraction, and require more epistemic authority: formulating hypotheses, probing and questioning, assessing and interpreting opinions, and so forth” (Medina, 2012: p.204).

This claim then, that experts by experience are informants, not co-enquirers, would be tantamount to allowing them opportunity to share their knowledge, without also extending to them the ability to question traditionally qualified experts, or to push back on the ways their testimony is being made sense of. This might, following the above, mean that we are epistemically objectifying such experts by experience. Could this be a plausible means of making sense of the cases I’m focused on? In some senses, yes, I’m inclined to think. However, the immediate barrier to accepting this as a full explanation of what is occurring in such cases, is that if a research team treat their experts by experience as mere informants, then they cannot, by definition, actually be coproducing research at all. As Arnstein’s *Ladder of Citizen Participation* (2019) can again help us to say, consulting a group of individuals – to seek their view, without them being able to guide or redirect a project – is an element in the participatory typology, but it is not at the level required to properly call something coproduced. 'Consultation' which is the only real means of making sense of treating an individual as an informant, allows individuals to "hear and be heard" (Arnstein, 2019: 25) is categorised as a type of tokenism which does not allow individuals outside of the controlling group to change or affect the status quo, or to determine the extent to which their contributions are heeded (2019: 25). Properly done, coproduction requires the ability to contribute, change, and challenge, working as equals in the research team. This, on Arnstein's ladder, would equate to a "partnership" working level, at minimum (2019: 25). Partnership working, represents a level of "citizen power with increasing degrees of decision-making clout. Citizens can… negotiate and engage with trade-offs with traditional powerholders" (2019: 25). And, clearly, in treating an individual as an informant, the ability to negotiate, and to make decisions is not had, as Medina's quote above illustrates. To view another's epistemic agency as a mere means for "carrying out [one's] own projects… [is to fail] to see them as an inquirer in their own right" (Medina, 2012; McGlynn, 2019: 172).

And so, very simply, epistemic objectification cannot be an explanation we accept for the cases I consider. This, we've now seen, is because, to treat someone as an informant is not to involve them as an equal partner in a coproduced research project. As such, there may well be epistemic objectification, but where that is the case, it isn't epistemic objectification in the context of coproduction; it simply cannot be as to treat experts by experience as mere informants is incompatible with the requirements for coproduction. The harm then, if you were to be sympathetic to the view that this *is* what's going on in the cases, would be to have misrepresented the nature of involvement – it is of course morally harmful to promise someone that their involvement will be equal in standing to your own (as a researcher or clinician) and to then treat them as a source of information and not as a peer who can, just as well as you, direct, or question research findings.

And despite my protestation that epistemic objectification renders it impossible that coproduction is taking place, I do think that some instances could be explained in this way. In such cases, the harm would be a misrepresentation of the level of involvement to be extended to experts by experience, or a lack of understanding or recognition of expertise from experience. This, largely, I suspect is due to the perception of coproduction as a 'gold-standard' research methodology and the onus or emphasis upon patient and public involvement from a range of research funders which might lead to research teams badging their work as 'coproduced' when in actuality, it would be better described as having undertaken patient consultation. The dilution of the concept of coproduction, I suspect, is in part what explains some negative experiences, as patients may very well expect one thing, and find their reality significantly diverges from that expectation.

Where this has led us, then, is to a conclusion that epistemic objectification may well be in play in some cases where experts by experience feel done-to rather than part-of in research. This, I suspect, is further accompanied by a degree of fungibility on the part of some research teams, whereby patients are not sought out for their particular views, but rather are viewed as loosely interchangeable, and as lacking salient differences which would make one patient a suitable expert by experience for a research project, and another lacking in a relevant area of experience (Davis, 2020).[86] I think the emphasis on coproduction on the part of funders, and the academy, is especially salient in making sense of these harms, as I'll go on to explore in the following Chapter. Research may be more likely to be funded if it can

---

[86] Fungibility, along with instrumentality, and inertness (where this is understood as lacking in agency) are all key criteria for epistemic objectification, as Martha Nussbaum (2006) explains it.

said to be coproduced, whether that is, or is not, the actual methodological approach that the research team can, or will, utilise.

For now, suffice it to say that whilst epistemic objectification plausibly captures a relevant aspect of expert by experience reality, we cannot hold onto the notion of coproduction as the research methodology at play and make an appeal to such a view to explain the cases I have set out. The harm, if we were to commit to epistemic objectification would lie in the mendacious invitation to participate in research as an equal, and would thus be largely moral. The individuals could well also be harmed in their capacity as knowers, by having such capacity *qua* epistemic agency denied. However, for now, I set aside this as a plausible explanation of what's at play in the cases I am considering.

3.1 – Othering: Selective subject status

A distinct, though related, argument however – though one which I suspect may encounter the same sorts of objections, though may be trickier to pin down – is that of 'epistemic othering'. As we have seen, most instances whereby an expert-by-experience fails to gain the uptake, or bring about the shifts in collective knowledge they intend, relate to instances where the knowledge offered is in some way deemed contentious. This can, though need not always be, related to anti-psychiatry sentiments, or to the voicing of views deemed otherwise oppositional. Such views might challenge the need for psychiatric medication, coerced treatment, or even be framed as in opposition to eliminativist approaches to psychiatric symptoms.[87] Doctors, psychiatrists, and even academic researchers have, as I

---

[87] Such eliminativist views I consider to be akin to similar views relating to physical disability. In bioethics, for instance, eliminating hearing loss, despite a Deaf community who do not wish to do so, or seeking to remove other physical conditions which disabled people view as 'mere-difference', are the sorts of positions one might see (and for more on these views see especially Barnes (2016: ch.1)). For arguments against psychiatric pathologisation, where members of the 'consumer, survivor, ex-service user (c/s/x)' movement claim

have argued, a great deal of power. When compared to those with mental ill health, particularly accounting for intersectional experiences of marginalisation relating to sex, gender, or ethnicity, the clinicians or researchers are undeniably the ones in control of the research process – this is insofar as they are the grant-holders in most instances, even if they fully intend to share the control of the research with experts by experience. They are thus the powerful 'party'.[88] Anti-psychiatry type views, or testimony which challenges the legitimacy or efficacy of psychiatric medicine, may well be viewed as hostile, or in some way threatening to the ongoing legitimacy of psychiatry, and thus may be dismissed as a manifestation of psychiatric illness. What I find interesting, in surveying the illustrations of expert-by-experience dismissal, is that it is only these more challenging assertions which appear to be subverted or dismissed. Views which would be deemed compliant, or which agree with the status quo, often meet no resistance at all. In fact, those whose testimony or knowledge cohere with what is believed or accepted by the traditional medical experts, appear to experience dismissal or distortion of their narratives to a much lesser degree. This supports a view whereby experts by experience *are* included, and that inclusion extends to them as subjects, just so long as their views, testimony, and inquiring supports (or rather does not challenge) the dominant status quo. Gaile Pohlhaus Jr. (2013) and Emmalon Davis (2020) have discussed this as giving one a sort of 'semi subject' status: that of epistemic 'other'. In occupying the position of epistemic other, Pohlhaus Jr. explains:

> "the sole purpose… is to provide epistemic support for navigating the experienced world of those deemed subjects. In this relation, those persons treated as "other" serve to recognise and maintain epistemic practices that make sense of the world as experienced from dominant subjectivities, but do not receive the same epistemic support with regard to their distinct lived experiences in the world. In the subject/other relation, recognition is

---

commonly medicalised symptoms of mental ill health are too mere-differences in function, see particularly Rashed (2019: ch.1).

[88] Foucault, for instance, argued that all medical power, and especially psychiatric power, has to do with political power and control. See for example, his (1994) '*Psychiatric Power'*, or *Madness and Civilization* (1988).

> monodirectional as opposed to intersubjective… it is also a kind of relation that Beauvoir judges to be fundamentally unethical since it denies a person's full status as a free subject capable of experiencing and giving significance to the world uniquely"
>
> (Pohlhaus, 2013: 105).

The position of *epistemic other* is then almost that of derivative subject. An expert by experience may be able to assert her view perfectly well, so long as she supports the consensus of the dominant group (the clinicians and researchers with whom she works). Her participation in such instances, serves only to legitimise their research endeavour, perhaps by satisfying funder requirement, or by giving the illusion of participatory research practice. It cannot though, be seen as a true investigative attempt to understand the world from the viewpoint, vantage or position of the most marginalised (Pohlhaus, 2013; Medina, 2012, McGlynn, 2019). And, as Ann Cahill has argued, the derivatisation of semi-subjects means that:

> "should [they]… dare to demonstrate aspects of […] subjectivity that fall outside of the derivatizer's being – assuming such a demonstration can even be perceived (it may well be so incomprehensible so as to be beyond the perceptual range of the derivatizer)– she will be perceived as arrogant, treasonous, and dangerously rebellious"
>
> (Cahill, 2011: 32).

This, as I indicated above, is precisely what we have tended to see in cases where experts by experience have their testimony called into question, or worse, have their experiences reviewed as if in psychiatric assessment, despite allegedly being equal research partners. And so, the notion of 'othering' manages to capture well, in my view, an important element of what may be at play. The issue with gesturing towards this as an explanation, is that it, like *epistemic objectification*, relies on there being an unequal distribution of participatory power between academics/clinicans and experts by experience. Experts by experience should be able to disagree with views given by the academics and clinicians in the research team. As I argued above, understanding of expertise as being only a confirmatory function may be plausible, but we could not argue along such lines and simultaneously make a claim that the research project being analysed was, in fact, coproduced. The difference in this latter case, is that I think it possible, and perhaps even plausible, that *epistemic othering* could manifest in scenarios whereby the research team fully *intend* to work in partnership with experts by experience in an Arnsteinian sense, but where the societal structures which subjugate those with mental ill health serve to work in the background, undermining attempts to introduce knowledge which could require seismic shifts in commonly held belief. What epistemic othering fails to do, however, is to explicate what such social structures might be, or how they may mechanistically operate. As such, whilst I think epistemic othering is explanatorily promising, and perhaps along lines which begin to get to the heart of what happens in coproduction – as I'll say more about in chapter four – in its present form, epistemic othering serves only to explain individual instances of the phenomena I consider. The treatment of experts by experience as *pseudo*- or semi-subject, though will feature in what is to come. However, alone, following Medina, I am of the view that a framework which can only be applied to the level of individual moments or testimonial exchanges, pays short shrift to broader socio-political arrangements. Thus, if there is a view that allows us to say more of the systemic nature of such cases, we ought to prefer it (Medina, 2012: 59; Coady, 2017: 64).

Further, whilst I indicated epistemic othering makes room for well-intentioned research teams, it could be argued that it does still require a degree of complicity on the part of the academics and clinicians, insofar as challenges to, or dismissals of, expert by experience voice are only located at those points where disturbance to the status quo would otherwise ensue. Entering into research with a closed epistemic horizon, or an unwillingness to have one's hypotheses proven wrong, could be understood as an epistemic short-sightedness, or vice. Nonetheless, as Sally Haslanger notes, we often do just that, as the ubiquity of confirmation bias demonstrates – "the world supports what we expect because we have made it that way" (Haslanger, 2017: 283).[89]

4 – Situated-ness, knowing, and refusing to acknowledge

Of course, Haslanger's point is not all that contentious – it is undeniably the case that the situations we find ourselves in, the social groups we are part of, and facets of our identity which are perceived as salient do shape who we are, and relatedly, what we know (or can be presumed to know). Our milieu then, is of huge importance in our world understanding. And noting as such, there are a cluster of theories of epistemic injustices which relate precisely to what can be known, or understood, by certain groups based on their positionality.[90] The two theories along such lines that I will consider here are *contributory injustice* (Dotson, 2012), and *hermeneutical injustice* (Fricker, 2007). Both of these accounts have been proposed as ways of making sense of how experiences can be (mis)understood based on where one reasons from. I take the second of these concepts first, as I think it more straightforward to refute as being applicable to coproduction.

---

[89] Confirmation bias is a type of bias which has been theorised as constricting ones' attention leading to disproportionate weight being given to facts or signs which appear to support a view already held or favoured, or alternatively as a sort of blindness to those things which may disprove, or reduce the credibility given to that sort of favoured view. For more on confirmation bias, see in particular: Nickerson (1998), Myers and DeWall (2015) and Peters (2020).

[90] Whilst I won't explore it here, standpoint epistemologists argue particularly vehemently for this sort of view, whereby one's environment determines what you can know, and also what the limits of that knowledge are. A wealth of articles focus upon this topic, so many that it is impractical to list them all here, but you might consult Pohlhaus Jr. (2011) and Toole (2020).

4.1- Hermeneutical Injustice: Marginalisation and Impasse

Hermeneutical injustice, as Miranda Fricker explains in *Epistemic Injustice* (2007), differs from testimonial injustice insofar as it does not relate to the downgrading of credibility on the basis of stereotypes or prejudice, but instead focuses upon the social position of individuals and the ways in which important aspects of their experiences can be impossible to make sense of due to prejudicial flaws in the interpretative resources available to them. In short, when a dominant group controls the narrative, experiences of the marginalised, minoritised or subjugated can be difficult to make sense of, as access to concepts and the power to shape those concepts such that they take on appropriate meaning in dominant domains are skewed in favour of the more dominant group. The illustrative example used by Fricker, and indeed by others when discussing this seminal theory, is that of sexual harassment – prior to use understanding the phrase 'sexual harassment' in the way that we presently do, a way of conveying what the term now means did not exist. Women simply did not have access to a concept to describe sexual harassment despite knowing all too well what it encompassed, and found that the extant concepts did not adequately capture important facets of what it was to be sexually harassed (2007: 150-151). As such, in attempting to explain their experiences, they were unable to convey the particularly pernicious and enduring nature of what we now understand as a widespread, sociopolitcally problematic, gendered, phenomenon. The rendering of women as incapable of making sense of their own experience, Fricker says, is a hermeneutical injustice – "the injustice of having some significant area of one's social experience obscured from collective understanding owing to persistent and wide-ranging hermeneutical marginalisation" (2007: 154). *Hermeneutical marginalisation*, Fricker explains, is to be marginalised on the basis of one's membership of a non-dominant group, whereby members of that group are subject to unequal hermeneutical participation (2007: 152-3). And, this membership might be transient or changeable, reflecting that often we are members of multiple different groups all at once. For instance, in a situation where gender is salient, or determines hermeneutical power or participation, the fact that I am a woman might render me a member of a non-dominant group and I may find myself in a position which is hermeneutically marginalised, but in same group, where educational status is salient, and those who have attended University are the dominant group, I would not find myself marginalised as such. We each have multiple, and multi-faceted identities, and this means that "hermeneutical marginalization affects individuals in a differentiated manner; that is, it may affect them *qua* one social type, but not another" (Fricker, 2007: 154). When we find ourselves in a non-dominant group frequently, as a result of some structural power difference, and thus cannot make sense of an experience we have as we do not have access to the right kinds of concepts, this can be a hermeneutical injustice, which is epistemic, Fricker argues, as it affects what we are in a position to know (2007: 154-157).[91]

I indicated scepticism when first mentioning hermeneutical injustice with respect to the tenability of it as a theory which could be used to explain the dismissal of expert by experience testimony. The reason for this is the lack of mention in any accounts of negative experiences in coproduction of an inability to 'find the words' or to 'get across' the message that an expert by experience wanted to convey. The issue, as I am understanding it, is not that expert by experience members of the research team can't find the right words, or

---

[91] Again, one might question whether this is quite right. Returning to the example of sexual harassment, before the term itself, it was not the case that women did not *know* they were being pursued in unwanted ways, or were having undesired sexual advances made toward them, it was, rather, that their ability to communicate those experiences, using a commonly understood concept, was impeded. As with my concerns regarding testimonial injustice, this is not an issue for the current exposition of Fricker's work, but could be a challenge one could raise against it.

locate a concept that seems apt to explain their view, it's that their view is itself, not accepted. This lack of acceptance manifests as undermining, or disbelief, misconstrual or pathologisation; perhaps leads to having one's view understood as the result of mental ill health. In none of these cases, though, does the issue at hand seem to be the lack of interpretative resources.

An alternative way of drawing on the idea of hermeneutical resources as the explanans of the cases I'm focussed upon though, might be to think about the differing concepts likely in daily use by those experts by experience, and the clinicians and academics in the research team, respectively. Such investigation may yield a picture whereby each group utilise a set of shared resources, individually, and also places where those resources are used with different meaning by each group as a result. In such instances, there may arise misunderstandings that could be understood in a way Luvell Anderson has termed *hermeneutical impasses* (2017). These, he explains, are "instances in which agents engaged in communicative exchange are unable to achieve understanding due to a gap in *shared* hermeneutical resources" (2017: 3, emphasis added). Concepts and expressions, manners of speaking, and conceptions are all things in the broader genus of hermeneutical resources that Anderson takes himself to be referring to (2017).[92] When individuals communicate with one another, as Gricean conversational maxims illustrate, a speaker tends to (and, according to Grice, should have) an intent to invoke some reaction, be it belief, surprise, or assent, in her audience (Grice, 1989). Utilising the hermeneutical resources that she has access to, the

---

[92] Goetze (2020) discusses this at length. José Medina also considers a sort of contextualist picture which is polyphonic in that ones' hermeneutical landscape is characterised by "heterogeneous publics with diverse resources" (2012: 211). I take 'shared hermeneutical resources' to refer to the pool of collective communicative practice conventions which one draws upon in determining how, what, and perhaps when, to say, which I see as being broadly in line with Anderson's depiction of Goetze's view, though, like Anderson, I am sympathetic to Medina's sort of view.

speaker thus selects the appropriate concepts to convey her point, and which she hopes will bring about the intended response in her audience. However, what Anderson illustrates is that hearers each have their own set of hermeneutical resources, that they share with their relevant peer group, and which may or may not cohere with the speaker's, depending on whether the groups overlap or whether conceptual consensus is sufficiently shared both intra- and inter- group. Thus, what is actually understood *qua* interpreted by that hearer, will depend upon *their* hermeneutical resources, and not those the speaker relies upon (Anderson, 2017). This can, though, allow both parties to *think* they've been clear/understood as intended, as I'll come on to discuss in a moment.

So, applied to coproduction, we may well envisage that, as a hermeneutically marginalised group of knowers, experts by experience share some hermeneutical resources with one another – perhaps concepts to explain the feeling of being over-medicated, as Lakeman's quote earlier in the chapter indicated – and, that medical professionals, or academic researchers, share what are perhaps a different set of shared hermeneutical resources. There will of course be overlap, but the two 'groups' might use the same phrases to convey markedly different things. What Anderson's view helpfully explains is how sometimes, these potentially intersecting resources can allow both speakers and hearers to feel as though they have understood and have been understood, in the ways intended by their conversational partners, despite both having completely different comprehensions of what understanding would comprise of. The example Anderson begins with is 'Black Lives Matter' and 'All Lives Matter' (2017). 'Black Lives Matter', following George Floyd's murder in 2020 was intended to convey anger at racialised police violence, and to be a way of calling attention to the disproportionate rates of Black men's deaths at the hands of law enforcement. In short, 'Black Lives Matter' was a cry for racial equity. Some, however, understood 'Black Lives

Matter’ as excluding non-Black individuals, as though prefixing the statement with ‘only’ (as in ‘only Black Lives Matter’) which was *not* the intended interpretation. ‘All Lives Matter’, similarly, could be understood in a number of ways depending upon the hermeneutical resources you rely upon. At its most inclusive, ‘All Lives Matter’, literally read, appears to also be a chant for racial equity, and equal weight given to all individuals. At its most pernicious, ‘All Lives Matter’ became a counter-chant to ‘Black Lives Matter’, ordinarily deployed by those who had assumed a prefix to the earlier chant which they presumed excluded them.

All groups in these examples would likely be resistant to correction, but, as Anderson notes, the most dominant social group – in a structural sense – will almost always have the power and control to determine what can and cannot be given up in terms of understandings. And so, if white counter-protestors, shouting ‘All Lives Matter’ refuse to accept that ‘Black Lives Matter’ is not an exclusionary chant, there is likely little that marginalised groups can do to persuade them of this. Interestingly, though, those chanting ‘All Lives Matter’ could believe it to mean either interpretation listed above, and could be intending very different sentiments that, depending on their audience, may fail to be received as intended. A supporter of inclusion who really *does* believe that all lives matter equally might enthusiastically chant ‘All Lives Matter’ to an audience who might be members of the group more likened to believe racist tropes, and who might assume the supporter of inclusion shares their (racist) view. She thinks she is an activist for broad equality, they believe she is signalling that Black lives ought not to matter in the same way: both parties feel as though they understand and have been understood, despite there being little common ground between them. This is a characteristic hermeneutical impasse. You may be wondering, why am I talking about racial justice protest chants when attempting to make sense of the exclusion of experts by experience? Well, I think the principles may apply just as well in the coproduction case as in the example above, albeit in ways harder to contextualise.

Imagine that in a research project the experiences of patients with a diagnosis of a personality disorder, who have been hospitalised, is being discussed. This could perhaps be as a means of ascertaining what an appropriate length of stay is for individuals experiencing acute distress.[93] The experts by experience, supportive of admissions for patients on a voluntary basis in such scenarios, might say something along the lines of “well, when I was in hospital I found it comforting to know that there was always someone there to talk to, and I couldn’t hurt myself, even if I wanted to. It made me really worried about going home”. Here, I imagine that the experts by experience really do intend to convey that their experience was positive, and the hospital environment felt in some way comforting. The clinicians or academics, however, may hold the view that such patients often do poorly on the ward, perhaps escalating or destabilising further. Given this pre-conception, it is entirely plausible that the clinicians on the research team could take the expert by experience position to be confirming their already held view: patients become reliant on others to keep them safe, and may therefore struggle to return to the community where support is less immediately available. Hospitalisation, then would not be recommended. The academics and clinicians may feel as though they have, then, understood the expert by experience, who no doubt hoped her words would be taken at face value. The speaker intended to convey a sense of comfort, the audience, relying upon their own interpretative tools, make sense the utterance using the hermeneutical resources available to them, leading to an impasse. Even if the experts by experience in this situation did attempt to correct the shared

---

[93] My example here is fictional, though there have of course been research projects seeking to explore this topic. The sorts of interactions I use in what follows are broadly imagined based upon research covered in Maconick et al’s systematic review of the topic (2023).

view, reiterating that they really did mean that being in hospital was a positive experience, I suspect, given the power dynamics at play between patients and clinicians, this would not suffice to remedy the misunderstanding, and may even exacerbate it.

The reason I am unsatisfied that this settles the question of how we might make sense of what's at play in the central type case is because it provides us no means of making sense of the measures required to redress the confusion, nor does it get at the crux of what I believe to be harmful and wrongful in such instances: hermeneutical impasses might be a helpful feature, but as a view to explain what is going wrong, they get us no farther than a mechanical understanding of concepts. You might, of course, be of the opinion that there *is* nothing further in play here, and that differing conceptual resources are just a matter of course, with little to be done about them. However, I'm inclined to believe that given historic power dynamics between patients and clinicians, and the move to coproduction as a means of ensuring that balanced views and lived experience factor in to medical, clinical and academic research, we ought to be at least willing to revise or expand our shared hermeneutical resources to make room for such differing opinions. And this does seem to be what happens, albeit not necessarily on the part of the clinical or academic parties. Experts by experience rely, in some instances, upon biomedical knowledge that they have amassed in order to 'speak the language of' their clinicians, necessarily medicalising their own narratives to ensure they are taken seriously (Dumez and L'Espérance, 2024).[94] Literature on expertise by experience more broadly indicates that part of what should determine or

---

[94] HydÈn and Sachs (1998) say on this self-medicalisation that: "To express one's suffering in terms of illness means that it must fit into and fulfill certain criteria and preconceptions about disease and it's treatment... this means that to have suffering recognized as a disease and to obtain relief, patients must transform their suffering in a way that enables them to seek help and be accepted as patients for medical care" (1998: 76). This could be read as a learning of the medical use of particular concepts and terminology, and applying them in clinical discussion. If this does indeed take place in the clinician's diagnostic room, there is no reason to suppose that it could not also be at play in coproduction.

underlie one being categorised as an expert, is a knowledge of how to *articulate* one's experientially gained knowledge (Borkman, 1976; Casman, et al. 2010; Castro, et al. 2018). And as much as I'm inclined to argue that the burden here ought to also fall on the clinicians and academics to do more to learn about ways experts by experiences describe the world, even in the absence of such argument, we can almost certainly say that checking one has been understood, and has understood, should feature within coproduction. There are, of course, instances where what a patient says should be interpreted, but the way we relate to patients in a clinical setting is the same as the way we should relate to experts by experience in another. Thus, the intent should be to take experts by experience at their word, and not to apply our own interpretative lens to their contributions, wherever possible.

4.2 – Situated ignorance and biased resources: contributory injustice

So far, then, I have argued that hermeneutical injustice does not seem particularly apt in explaining the cases I consider. I have noted that hermeneutical impasses may lead to mistaken confidence in understanding, but that confusion in meaning alone fails to get us to a picture that explains what is both harmful and wrongful in cases where experts by experience have their testimonies discounted or distorted. What we could consider then, is whether *contributory injustice*, as a view that is strikingly similar to Anderson's position, might provide better explanation.

Kristie Dotson (2012) argues, like Anderson, that we ought to believe that there are multiplicities of hermeneutical resources in play in communities. These, she says, are sorts of alternative epistemologies, upon which we rely to make sense of the world.[95] When those

---

[95] Whilst *alternative epistemologies* appears to be a new concept, I understand it as having a very similar meaning to 'shared hermeneutical resources' and thus will proceed without explicating this further.

resources, upon which we rely to make sense of the world, do not accord or extend to some particular experience, or perhaps better, elide important elements of that experience, this, Dotson claims is to be in a position of *situated ignorance*. That is because, as we saw in section 4, one's positionality affects what one is able to know and the sorts of epistemic resources, or hermeneutical resources, at your disposal (2012: 31-32).[96] Contributory injustice, Dotson claims, arises when I as a perceiver, or hearer, refuse to acknowledge that there are alternative epistemologies which could be used to make sense of the world, and insist on applying my own interpretation, based upon my own shared hermeneutical resources, despite that giving rise to a meaning which was inconsistent with the speakers' intent (2012: 33-34). Particularly, for Dotson, this is the case when the shared hermeneutical resources upon which I rely are prejudiced or biased in an important way, and this bias gives rise to the misinterpretation that I make. The injustice then, lies in my refusal as an epistemic agent to recognise the bounds of my own epistemic limits, or to acknowledge that those limits, and the contents of my epistemology, are made up of prejudicial attitudes, which are particularly disposed to understand the world in a certain way. And this recognition of one's own epistemic limits, I argued at the end of 4.1. should not be one-sided, inasmuch as it ought to be something that the academics and clinicians – one could argue it should be *particularly* the academics and clinicians – also consider, and take action to mitigate. Maintaining and continuing to utilise epistemic resources without an attempt to consider their objectivity, or to consider the ways in which they might subjugate or undermine others' ways of viewing the world, gives rise to misinterpretation (like in the case

---

[96] Situated ignorance could be understood as being similar to Pohlhaus' 'wilful hermeneutic ignorance' (2011), though we could conceive of situated ignorance without ill intent. As we'll see, though, even innocuously appearing situated ignorance can give rise to contributory injustice.

of hermeneutical impasse) which could readily have been avoided, had I been willing to expand my hermeneutic horizon (Dotson, 2012).

Applying this to the example of the expert by experience with a personality disorder diagnosis, then, allows us to say that the clinicians and academics in my fictional scenario are wilfully ignorant, in virtue of their positionality as psychiatric professionals. Their unwillingness to acknowledge a potential alternative meaning to the expert by experience contribution that the one that they infer, or interpret, is indicative of their *situated ignorance*, despite the ever-growing body of literature which explicates that mental ill health related medicine can be, and has been, particularly prejudicial with respect to its patients.[97] Is it fair to say, though, that the academics and clinicians in this scenario ought to be aware that there are other ways of making sense of the world? I think absolutely. Activist, or c/s/x movements have been around in psychiatry for some time.[98] And thus even though the example I am describing is not necessarily one which relies on experts by experience expressing a strong anti-psychiatry view, I do not find it a plausible claim that academics and clinicians whose focus is mental health may not be aware that their worldview is shaped by their profession and professional beliefs, and that those beliefs may not be shared by others.[99] If this seems too strong a claim, I think we could also appeal to the skewing or biasing of hermeneutical resources in the medical profession, which support a tendency to interpret testimony as a source of diagnostic information. As Harcourt (2021) has shown, interpretation is not always the aim of interactions, but it can be, and the example I gave

---

[97] You could, for example, draw on a range of histories of mental ill health (such as Scull, 1981; Scull, 2015) or even on notable anti-psychiatry authors (for example, Szasz, 1974).

[98] For an excellent overview of the histories of such movements, see especially Rashed (2019, ch.1) and Beresford and Russo (2022).

[99] If you are unpersuaded by this for the example I give, any instance of an expert by experience conveying something, either using terms or by expressing sentiments, which could be understood in two differing ways could easily take its place.

above could well be illustrative of the fact that even when not in a diagnostic setting, being given the label of 'mentally ill' is sticky, and can carry through to other interactions you have as an individual (Scrutton, 2017). In severe mental ill health in particular, Anastasia Scrutton notes that the dominance of psychiatry, and power imbalances, can give rise to one-sided interpretations of what patients say. Scrutton argues that having received a past mental ill health diagnosis can result in confirmation type biases which then impact the believability or receivability of what an individual then goes on to say, even if those patients are well and partaking in communicative exchanges outside of the clinical setting (Scrutton, 2017; Mason, 2011). Such patients may then experience injustices in both testimonial and contributory senses.

I find it, therefore, entirely plausible that the resources upon which clinicians and academics both use, and rely upon, are indeed medicalised, and perhaps even make room, on occasion, for alternative understanding of mental health related distress or illness. Such alternative understandings might, to use Dotson's terminology, be understood as 'alternate epistemologies'. These differences in understanding cannot be merely integrated into the dominant view, though some kind of remediation would be required to prevent contributory injustices arising from them. This remediation – or the expansion of dominant hermeneutical resources to make room for alternate narratives – would minimally require, for Dotson, what Mariana Ortega has called 'world travelling'. This means of not simply learning about (theoretically) others' experiences, but immersing oneself in other cultures, ways of being, and social environments is, both Dotson (2012) and Ortega (2006) believe, required to redress contributory injustice in non-tokenistic ways.[100] The demands of

---

[100] It would be remiss of me not to note that Ortega's '*Being Lovingly, Knowingly Ignorant*' presents a view which is not wholly dissimilar to contributory injustice of hermeneutical resource gaps between communities, which I suspect could be used just as well here.

acquiring the right alternative epistemologies in such ways are likely huge, and I would argue, are impracticable, insofar as world travelling would require clinicians and academics to also experience mental ill health and all that goes along with it. Such experience with mental ill health is not something one can will. As Cath (2018) and Faulkner's (2021) arguments in chapter 2 demonstrated, the what-is-it-like*ness* knowledge, that appears to be at least part of what would be required to develop a full understanding of how one might see the world as someone with experience of mental ill health, could not be arrived at, or truly felt in any way but by having that experience for oneself. Thus, whilst contributory injustice does seem to aptly capture differences in our hermeneutic horizons, the practicalities of redressing it in these ways would be at best, onerous, and more likely, impossible. Minimally, it would require that clinicians and academics were able to recognise the bounds of their own knowledge, and the limitations which necessarily accompany that knowledge, for each and every communicative requirement. And this, Dotson says, relegates:

> "efforts to be conscious of and minimize epistemic oppression to a kind of naivete characteristic of utopian dreamers who advocate pie-in-the-sky goals achievable only in theory"
>
> (2012: 25).

Where this gets us to, is a place where contributory injustice, much like many of the other views I have considered in this chapter, could plausibly explain some elements of what might be at play in the central cases I am considering. What it likely does not give us, for the reasons just outlined, is any plausible means of redressing bias in our hermeneutical resources that we could actually implement. And, I'd like to go a step further and claim that by appealing only to situated ignorance and biased hermeneutical resources, we overlook an important element of what surely must have a role in the experiences of experts by experience – the role of stigma. We could, of course, claim that stigma just is precisely the cause of the bias in our hermeneutical resources, and of course, power to shape and shift such resources is an element of the contributory injustice picture. However, so too is one's standpoint. Extending Dotson's view to appeal more to histories of oppression as the root cause of stigma as part of its depiction of the epistemic harm could, though, be a way to go, as I discuss in the next chapter. I think we need not take the time extending the scope of contributory injustice in such a way though, for the very reason that Dotson herself does so, in her explanation of *epistemic oppression*. And so, epistemic oppression is to where I next turn.

5 – Concluding remarks

Here, then, I've considered a range of theoretical frameworks which might help to make sense of the central cases I focus upon. As I've shown, there is nuance required in the understanding of each, and though I think most of the views discussed within this chapter manage to successfully capture important elements of the exclusion of experts-by-experience, when applied to the central cases, I have also argued that they elide important aspects of experience. Testimonial injustice, as perhaps the most widely deployed means of making sense of unjust exclusions of testimony, I've argued, cannot help us to understand what's at play in a structural sense, as it focuses at the levels of individual interactions and considers credibility within the communicative exchange. Harcourt's work helpfully illustrates that oftentimes, the goal of psychiatric encounters is not to believe, which raised the question of epistemic objectification, and though I've argued this could be plausible, I also illustrated that epistemic objectification would render culpable clinicians who would have repeatedly mis-sold coproduction. I then outlined epistemic othering, and though I think it a useful concept, which begins to capture the essence of expert-by-experience participation, this too I've explained, is incompatible with coproduction and further fails to capture the ways in which testimonies are distorted.

I then moved on to consider hermeneutical injustice, though this I argued is the furthest from capturing what's at stake, as a conceptual lacuna does not appear to be the cause of testimony distortion or dismissal. Impasses, which might arise as a result of different parties' situatedness, however, I claimed did appear to capture an important and central element of the cases in point. However, given that Anderson's view is one in the tradition of speech-act theory, it gets us little in the way of an understanding of the wrongful or harmful nature of such lacunas in understanding. Contributory injustice, as perhaps the most promising view I've considered, begins to colour in this picture further, locating the harmful nature of such injustice in the situated ignorance, and biased hermeneutical resources upon which clinicians and academics may well rely. These concepts of situated ignorance, and of biased resources will be central in what follows, and, as I've indicated, I think it unwarranted to attempt to expand Dotson's picture, given her further work which I will now turn to explore.

In short, what this chapter has illustrated is that what conceptual framework suffices for our purposes depends on what we are attempting to explain – stigma, prejudice, deflated credibility, and tokenised participation are all elements of a picture that is tricky to unpick, and harder still to explain. Any one of these views would explain important aspects of the epistemic harm in play. None, however, that I have considered here, are able to capture the ways in which stigma, prejudice, etcetera, combine to engender the minimisation of expert by experience contribution. The work of the remainder of this thesis, then, is to to provide such an explanation.

Chapter Four: **Explaining the exclusion of experts by experience – self-levelling epistemologies and epistemic oppression**

1 – Introduction

I begin this chapter by picking up where the penultimate section of Chapter Three left off: with the notion of one's situatedness affecting what you can, or conversely cannot, know.[101] Of course, as we saw in Chapter 2, it's much more complicated than that in real terms; knowledge can be gained and lost, and be more or less specific to a particular domain. Even within a domain, knowledge and expertise can be developed to varying degree in a way which accords with one's experiences, and, one's situatedness. All of this, as we've seen culminates in the 'set' of hermeneutical resources we use to make sense of the world. And, as I also argued in the preceding chapter, I'm not only sympathetic to the view that this means we all have unique perspectives on the world, but also that those perspectives more or less cohere with those of our peers, whether in the workplace, or in our social circles. Simply: we share hermeneutical resources with members of our social group. These shared hermeneutical resources, in the preceding chapter I've argued in line with Dotson (2012), because of our situatedness are likely biased in favour of our own experiences.

Recall too that in part one, I also argued that having experience of mental ill health can plausibly give some individuals knowledge of a standard that might allow them to be considered experts by experience. And, I've claimed this knowledge is, in part, what makes the exclusion of experts by experiences' voices so problematic (read: harmful and wrongful) in coproduction. We should, epistemically speaking, listen to such experiences if we are

---

[101] As with the previous chapter, parts of the argument contained within this chapter are along similar lines, or make the same claims as I argued for in 'Co-Production and Structural Oppression in Public Mental Health' (2023).

persuaded that knowledge about lived experience might yield more holistic and broadly applicable perspectives on a topic (Glasby and Beresford, 2006; Sweeney, 2015).

Here, I'm going to give a mechanistic account of how the situatedness of particular groups, and the biased hermeneutical resources upon which they rely in making sense of the world, might preclude the possibility of expert by experience knowledge being able to be heard, and heeded, in coproduction. In doing so, I make one key assumption, and that is that in virtue of having lived experience of mental ill health, even those members of the research team who were previously 'peers' of the academic or clinical researchers, become in some way 'othered' when their participation is as expert by experience, and not as professional.[102] Experts by experience, insofar as they have personal experience with mental ill health are more likely to be subject to credibility-deficits because of that very experience, despite it being the reason for their invitation to the research table. The theoretical framework that I will then defend here is *epistemic oppression*. Specifically, I'll argue that third-order epistemic oppression can do some of the explanatory heavy-lifting that I have found other theories considered in Chapter Three unable to adequately explain.

To set the scene sufficiently, and to establish the underlying features of our epistemic practices that make epistemic oppression so well suited to the task at hand, we must begin elsewhere however; with an explication of how our epistemological systems have tendencies to 'self-level'. As such, I begin with discussion of José Medina's (2011) concepts of *meta-blindness*, *active-ignorance*, and *epistemic friction*.

I then move on to set out Dotson's account of epistemic oppression (2014), explaining how what has come before gives us reason to believe that this view makes sense of more of the

---

[102] Having seen Richard Lakeman's (2010) account of his inability to be taken seriously when discussing medication side effects in the preceding chapter, I do not think this a contentious claim.

important facets at play in the cases I am focused upon, than many of the alternative theories we might appeal to. The stigma that affects experts by experience, the norms of the academy, and our epistemological systems' need to avoid a state of flux, work as a confluence of factors to cast out knowledge that does not cohere with dominant ways of making sense of the world. Experts by experience, and indeed coproduction, this means, are doomed to failure in many circumstances.

2 – Epistemological systems and the boundaries of knowability: what we know and how we know it?

In chapter three, I touched upon the notion of shared hermeneutical resources, describing these as a pool of collective communicative practice conventions, and conceptual terms, which we draw upon in determining how to communicate particular experiences. These shared understandings, or ways of seeing the world, I've indicated, can be based upon ones' standpoint, or situatedness, insofar as our common interlocutors likely share the same conceptual frameworks as we. Talking the same language, and using the same terms, increase the plausibility that I can both understand, and be understood. However, when thinking about our 'epistemologies' or the systems which relate to our ways of viewing and knowing the world, often theorists have often talked of features additional to those already outlined, such as norms which govern our epistemic practice, and systematise our learnings, behaviours, and communicative practices, more broadly. These frameworks, some have called *social imaginaries*. But what a social imaginary is, and how it might relate to our understanding of the world, or the development of knowledge, will require more in the way of explanation. Of particular interest, in a defining of the social imaginary, is a description of what such imaginaries are, and what they may contain. Charles Taylor explains as follows:[103]

> "By social imaginary, I mean something much broader and deeper than the intellectual schemes people might entertain when they think about social reality in a disengaged mode. I am thinking, rather, of the ways in which people imagine their social existence, how they fit together with others, how things go on between them and their fellows, the expectations that are normally met, and the deeper normative notions and images that underlie these expectations… [the social imaginary] incorporates a sense of the normal expectations we have of each other, the kind of common understanding that enables us to carry out the collective practices that make up our social life… Such understanding is both factual and normative; that is, we have a sense of how things usually go, but this is interwoven with an idea of how they ought to go, what missteps would invalidate the practice"
>
> (Taylor, 2004: 23-24.)

On this view then, a social imaginary can be said to contain the rules, implicit in our social operations, which govern what we can, and additionally what we should not, do, and perhaps even determine how we relate to one another. Our own beliefs can be legitimised (or not) depending on how well they cohere with the norms as laid out within our social imaginaries (Taylor, 2004). Less explicit acknowledgement is given by Taylor of the operational workings of social imaginaries, although he alludes to them as being a sort of background, or pre-theoretical, yet ubiquitously instituted and widely shared, understanding of how the world and the societies within it, work. Applied specifically to knowledge and testimony, José Medina (2011) spells out a little more clearly what our instituted social imaginaries help us to do in practical contexts.[104] Medina argues that the social imaginary

---

[103] This, of course, is not the only place in philosophical literature where social imaginaries are explicated. José Medina (2011) relies heavily on Castoriadis' (1997a, 1997b, 1998, 2007) construal of social imaginaries, as well as that of Gatens (1995) and Gatens and Lloyd (1999). Medina himself understands the social imaginary as being: "a repository of images and scripts that become collectively shared. This symbolic repository provides the representational background against which people tend to share their thoughts and listen to each other in a culture" (2011: p.33 en.3). I have selected Taylor's discussion for the substantive point as I'm inclined to think that norms relating to our interactions with one another are likely contained within those imaginaries as well, though I think it would not adversely affect your understanding of what follows if you were to prefer to read with Medina's description of social imaginaries in mind.

[104] Following Dotson (2014) I use 'instituted social imaginary' here to denote a social imaginary which is widely in operation within some group or other, I understand it as broadly equivalent to 'operative' social imaginary.

gives individuals capacity to interpret and understand information ("opening their eyes and ears to certain things and not to others" 2011: p.27), and also shapes individual capacity to attune, to listen and to deploy accurately assignments of credibility and authority to interlocutors (2011: 27). Emerging then, is a picture which indicates that within a social imaginary, we have a kind of playbook for acquiring knowledge, communicating that knowledge – by relying upon the shared hermeneutical resources we possess – and understanding who and what to believe. Social imaginaries, then, appear to contain something related to, but distinct from, the conceptual content of 'shared hermeneutical resources' insofar as they contain the rules regarding what hermeneutical resources we can acquire, and how others may shape and change those resources upon which we rely. And, as we saw with contributory injustice, shared hermeneutical resources can be biased toward particular groups, or positions of privilege based upon abilities (or lack thereof) of particular groups to 'shift' or to 'change' either those resources. Having done the work of additional exposition, we might also say that the privilege to widen, broaden or perhaps even to change the rules of practice contained within the social imaginary which is instituted, lies with that dominant group. As I'll show in what follows, this matters in terms of the way we might recognise the bounds of our own knowledge, and thus either accommodate, or not, new ways of sense-making. Such new ways would be a 'shift' to a degree, of that social imaginary.

This notion of 'shifting' or changing the social imaginary, will be integral in what follows, but for now I wish to retain focus on our instituted imaginaries themselves. As Medina has argued, social imaginaries do not always work for the good of all, and can, at times, perpetuate (and perhaps even give rise to) epistemic injustices. For marginalised knowers, he argues,

> “authority is discredited because certain affects and relations have been rendered incredible (in fact, almost unintelligible) in that culture; and achieving justice becomes practically impossible in that culture until those affects and relations become imaginable, until they can be thought meaningfully, and those who lay claim to them do not become discredited by their very claims”[105]
>
> (Medina, 2011: 25).

This incredulity or unintelligibility that is a feature of the continued and perpetual marginalisation particular groups face, especially as their marginalisation relates to knowledge, should not be understood as unintelligibility *simpliciter*. Rather, it is unintelligibility on the basis of the social imaginary itself, given the constraints within the instituted system. Instituted social imaginaries, Medina argues, in line with Nancy Tuana (2004, 2006) promote epistemic habits “that protect established cultural expectations” (2011: 26). Simply: social imaginaries affect what we know, and how we know it, and an element of this relates to their absorbance of counter- information or practice.

This means that information which is contra to that which is accepted and coded within the instituted social imaginary, particularly if it is offered by a marginalised individual, may very well be ‘explained away’ as misnomer. Discrediting of authority works to maintain the status-quo at times, and as I’ll argue in section three, minority groups may struggle to gain sufficient traction to promote the sorts of shifts I have gestured toward. As I’ll say also below, this is precisely what appears to happen when expert by experience testimony doesn’t cohere with what is commonly accepted (in the dominant social imaginaries at play) in coproduced research. In discussions of epistemic othering, I noted that issues only appear to arise in coproduction in instances where the experts by experience attempt to introduce a

---

[105] I assume that when Medina says “in that culture” he means in the community in which the instituted social imaginary is operative.

view which is not that commonly held. This conception of the instituted social imaginary, then, may help us to explain why.

Explaining-away of incompatible information such as may occur when one knower discredits another, Medina claims, can be as a result of three key epistemic habits; (i) arrogance, (ii) laziness, and (iii) closed-mindedness (Medina, 2011; 2013: 39). These habits in conjunction, generate a kind of ignorance that Medina calls *active ignorance* (2013: 39). Active ignorance, which we could liken to a 'look no further' attitude, allows one to avoid the need for any further exploration of facts before making a judgement that this new, and incompatible information, could not be a plausible way of sense-making, in whatever context one reasons: one simply assures oneself there is no need to consider alternatives.[106] Incongruence with the social imaginary is unacceptable, or perhaps, as Medina has argued, unintelligible, as that imaginary controls how we make sense of, and describe, our world.

2.1 – Resisting counter evidence: active ignorance, meta-blindness

Active ignorance, as noted, refers to situations where epistemic agents develop epistemic habits, commonly understood as vices, exhibiting tendencies to cease inquiring as soon as they arrive at an epistemic position which they believe sufficiently explains topics at hand. This is usually in a way which easily assimilate their existing worldview. As we've seen, however, our worldviews (or shared hermeneutical resources, which I've argued are related to our social imaginaries as the content of our shared hermeneutical resources can only be acquired in ways congruent with the instituted social imaginary) can be more or less biased. A tendency to privilege our own way of seeing the world, as Harcourt (2021) discussed, can

---

[106] As we'll see, this is in part what meta-blindness is.

also constitute a type of epistemic arrogance. If, when presented with a counterfactual or alternate way of making sense of some event or other, I fall back on my own qualification, experience, or situatedness as justification to ignore contradicting evidence – as in the case of a psychiatrist who insists that their qualification makes them know best – I am, in effect, assigning myself a credibility excess, which may well indicate epistemic arrogance. Whether you are persuaded by the notion of epistemic arrogance or not, though, if you believe one could have done better by seriously considering alternatives to the curtailed inquiry undertaken, then it may be appropriate to ask whether an individual is exhibiting active ignorance.

Medina also (iii) indicates that a sense of closed-mindedness (a 'my way or the highway' type mentality) tends to be a feature of active ignorance. It is not that an individual is unaware that there could be other ways of seeing the particular topic at hand, because that just isn't plausible, at least not in coproduction – rather, an agent may be actively invested in their instituted social imaginary and shared hermeneutical resources being *the* way of sense-making. Or, perhaps better, and as Tekin argues can be the case in mental ill health, some agents might be actively invested in not expanding their view, or considering alternatives to it (Tekin, 2023). Such a position, Medina argues "comes with a battery of defense mechanisms" (2013: 39). These defence mechanisms, he argues elsewhere "make [epistemic agents within an instituted social imaginary] relatively deaf and blind to those things that seem to defy those expectations" (2011: p26).

Operating in a way that allows for these particular epistemic habits to take hold, though, creates more than just a culpability when it comes to ignorance. By so fully relying on instituted social imaginaries to make sense of the world and allowing oneself to become actively ignorant (by failing to seek out alternate explanations, by making presumptions about one's own epistemic superiority with respect to credibility, and by ceasing explorative work and refusing to consider alternate possibilities as plausible) we also exhibit an inability to know what it is that we do not know. This, Medina explains, is to develop *meta-blindness*.[107] Meta-blindness relates to our inability to detect what we are unable to understand, thus the higher level nature of it (Medina, 2011: 28). It is, then:

> "a particularly recalcitrant kind of ignorance about the cognitive and affective limits of one's perspective"
>
> (Medina, 2011: 29).

And, taken with what I have said so far, particularly thinking back to the discussions of hermeneutical impasses and contributory injustice, when we think about communicative exchanges which involve both privileged and traditionally subjugated knowers, the skewing of the dominant social imaginaries and shared hermeneutical resources, toward the privileged group, will likely mean that those in control (again, the privileged) will be aware of other ways of seeing the world, or perhaps the potential of other ways of seeing the world, but feel that *their* way of seeing the world explains away the alternatives very well, with little consideration that there could well be two distinct ways of making sense of the same thing.[108]

I want to pause briefly, to just unpick that last statement further. I've indicated that there *are* members of the privileged group who may well be actively ignorant, and may be exhibiting meta-blindness, but have also indicated that those same members might know

---

[107] Meta-blindness is also discussed by Kathryn Montgomery in her 'How Do Doctors Think?' (2006) and is described as an "epistemological *scotoma*, a blindness of which the knower is unaware" (p5).

[108] Assuming one does not take a dialetheist sort of view, it could also be the case that the privileged group think that whatever the new information they have been asked to consider is is in some way incompatible with accepted ways of seeing and understanding the world, and thus it must be erroneous.

well that there are alternate ways of seeing the world: how can this be the case? This, I believe, is where *pace* Medina I do not think it plausible that dominant groups do not have any peripheral awareness that for instance, racialised communities understand many of their experiences as having racist undertones, when the dominant group may see them as being perfectly explainable.[109] Nor, returning to the case in point, do I think it plausible that academics and clinicians do not know that patients oftentimes express dissatisfaction with their treatment, or understand it as 'dulling their creative senses' as opposed to treating an illness.[110] Rather, I think it a feature of the dominant epistemologies that they can merely explain away such alternate possibilities as explanations unviable to the research community, or, as I will come on to say, as very features of being unwell. So, in the case of racialised communities, it may be that the dominant group have, baked into the instituted social imaginary a supposition that Black people are more apt to describe any personal slight as carrying a racist undertone. In the case of mental health and medication, that social imaginary may view it as a feature of psychiatric illness that some patients feel their manic symptoms are a special kind of creativity.[111]

These underlying suppositions then, work to make sense of counterfactual or competing points of view, by neutralising any challenge that the literal meaning of 'that was racist', or 'psychiatric medicine harms, and pathologizes creativity' might present, thus assimilating the interpreted meaning in ways perfectly congruent with the instituted social imaginary.[112]

---

[109] For discussions of this see also Sullivan and Tuana (2007).

[110] In *How Do Doctors Think?* (2006), Montgomery explains that this could also be because clinicians are for the most part empathetic but uninterested, in the patient's experience of illness, but rather are focused only on the details required for clinical investigation and treatment (p.92).

[111] These are points to which I return in part three of this thesis.

[112] My thinking here is that this acts as almost the alternate side of the phenomenon of epistemic-othering (Pohlhaus, 2013) but from the perspective of the dominant group, insofar as the dominant group are happy to accept testimony which affirms their way of seeing the world, but are inclined to interpret testimony which does not sit easily with their world-view, changing the meaning of such testimony in ways that mean it coheres with what they already believe to be the case.

The dominant group still exhibit meta-blindness, but that meta-blindness relates to the inability of the group as a whole to detect, or even to comprehend, that their way of making sense of an alternative view was not the intended meaning of it.

For Medina, the antidote to meta-blindness, is *epistemic friction*. That is, the seeking out of contradicting and incongruent information, with which we ought to challenge ourselves. Friction seeking, Medina explains, requires us to commit to acquiring, or operating in accordance with epistemically virtuous principles of humility, curiosity and diligence, and open-mindedness; necessarily abandoning arrogance, laziness and closed-minded ways of knowing (2011, 2013). And with sufficient friction, it might be the case that some epistemic agents can expand or shape their hermeneutical resources such that they can account for competing understandings of the world, even if their situatedness makes them apt to prefer particular accounts. Recognising that there is an experience which cannot be explained by the instituted social imaginary without interpretation, as we'll see, may well be challenging. For a competing piece of information to have the scope or potential to present such a challenge, it must be categorised by the individual as something worth exploring further. As Goldman explains in his *Knowledge in a Social World* (1999), upon hearing some testimony or other, or perhaps witnessing an occurrence which to date one has limited knowledge of, one must determine whether and to what degree, to accept this as truth (1999: 104-105). In cases of testimony, such as in the case of coproduction, this corresponds to the assigning of a credal attitude: to believe, or not to believe, and to what degree (Goldman, 1999). And the resultant attitude, or degree of belief we might accord, and thus the amount of epistemic friction that counter-evidence to our previously held worldview might generate may depend both on whether we have strong reason to not accept the possibility of alternatives, and the intelligibility of such alternatives (Goldman, 1999; Burge, 1993; Harman, 1986).

In coproduction, of course, ‘belief’ or even ‘high credence’ may not be the aim of a discussion, or of the seeking of expert by experience views. Experts by experience, though, should, if they are truly equal members of the research team, be able to have their views taken with sufficient seriousness that the research direction, findings, or even outputs, might be affected and shaped by those views.[113]

2.2. – Stigma

If by now you are wondering how this relates to epistemic injustice, bear with me: all will become clear imminently. When I discussed contributory injustice at the end of Chapter 3, I noted that whilst the theory managed to convey a sense of how one’s situated ignorance and biased hermeneutical resources might contribute to failures to understand and be understood, it could not account for the role of stigma (which, as I argued in Chapter 1, and as I’ll revisit in Chapter 5, is rife in relation to mental ill health). I’ve now expanded the genus of concepts with which we are working such that we might review our understanding in relation to those concepts introduced in the discussion of contributory injustice. I’ve said that biased shared hermeneutical resources are shaped by the instituted social imaginary, as that imaginary contains the ‘rules’ for knowledge acquisition within the community. Situated ignorance, based on one’s positionality which affects one’s hermeneutic horizon, might be seen as a lesser type of active ignorance, or, could I’m inclined to think, be seen as broadly equivalent to that collection of epistemic vices which preclude or limit understanding.[114]

---

[113] I am not sure that ‘belief’ or ‘credence’ quite capture this.

[114] You may be unpersuaded that the two are interchangeable, and indeed, I am not arguing that situated– and active– ignorance are conceptually identical, only related. Rather, I think for my purposes, it is fine to understand them both as being broadly positions which give rise to meta-blindness, and which limit the scope of one’s epistemic pursuits.

Now the seeking of epistemic friction could, I'm also inclined to think, be similar to, or even require, the 'world travelling' that Ortega (2006) describes as being needed to acquire alternate epistemologies. But, here, we're not actually looking to acquire a new epistemology, more we're looking to expand, generate, or improve knowledge within our operative epistemology. Thus, the requirement may be far less onerous than Ortega's proposal. But you could argue, as I suspect Ortega may, that in order to bring together opposing views in a coherent way, such world-travelling would be required, in order to make objective those shared hermeneutical resources upon which we rely. As I argued above when discussing meta-blindness, though, I think the broader and more pressing issue is the way in which those biased hermeneutical resources, as part of the instituted social imaginary, often manage to make sufficient (for the dominant group) use of competing narratives, by subverting, or interpreting those narratives (inaccurately) in ways which maintain the status quo. When this happens, the epistemic agency of individuals who are trying to convey *x* but whose contributions are understood as being intended to mean *y* is undermined. And this undermining of epistemic agency, we've seen, is what points toward epistemic injustice. In coproduction in particular, one of the reasons I think this rife relates to the role of stigma, as an operative sociopolitical facet of the instituted social imaginary, especially as it relates to those with mental ill health. The reason I argue as such, which I've begun to allude to, is that recognising one's own meta-blindness – in the sense of actively seeking epistemic friction – requires that there is evidence of high credal value, which one acknowledges cannot be accommodated by the currently instituted social imaginary. I think it plausible that only a highly credible individual would be able to bring about such a seismic acknowledgement, perhaps by contributing evidence or narrative which is considered to have such a high credal value. As I've argued throughout this thesis so far, individuals with histories of mental ill health are routinely considered *in*credible and as a result of the stigma surrounding mental ill health, are much more likely than you or I to experience credibility-deficits in their routine interactions, even when those interactions have little to do with their experience of being a psychiatric patient (Scrutton, 2017; Crichton, Carel and Kidd, 2017; Kidd, Spencer and Carel, 2022; Spencer and Kidd, 2023; Kidd, Spencer and Harris, 2023). Therefore, I think we cannot discount stigma as a part of the explanation of experts by experience failure to generate epistemic friction.

In co-production, this gets us to a seemingly bizarre view. If you accept the arguments thus far: (i) we do have reason to believe that (some) individuals with lived experience of mental ill health possess some level of expertise which differs in some ways from expertise held by doctors (from Chapter 2); and (ii) coproduction brings together those experts by experience to partner with academics and clinicians, as co-researchers, pursuing knowledge advancement (from Chapter 1). But then, (iii) in order to affect advancements in dominant understanding, information must either cohere with commonly accepted information, or must be presented by a highly-credible individual such that the epistemic friction generated is sufficient to lay bare the limits of the instituted social imaginary. Lastly, (iv) experts by experience, in virtue of their mental ill health, are routinely *not* deemed credible informants.[115] And so, pragmatically, there is a problem evidenced by (i)-(iv): experts by experience can only contribute to knowledge advancement if the information they offer coheres with the content of the instituted social imaginary. Otherwise, they risk being dismissed, or having their narrative subverted or interpreted by the clinicians or academics who are members of the epistemically privileged group. This, you might think, just is the

---

[115] I accept the use of 'informants' here may be slightly misleading, as I've argued that in coproduction (properly construed) experts-by-experience can not, and should not, be mere informants. Here I'm using the term in a more colloquial sense of the word.

premise of epistemic othering, as discussed in Chapter 3. However, whilst epistemic othering, as we have seen, explains the ways in which narrative makes it, or doesn't, into shared understandings based on the affirming of the dominant view, the picture here goes beyond that, as the underlying concepts of meta-blindness, and the credence required to present sufficient epistemic friction supplement the picture of epistemic othering to not only explain the 'what', but also to begin to gesture toward the 'how' of epistemic injustice in the sorts of cases I'm describing.

The task at hand now, then, is to give an account of how this problem, as I've described it, harms the experts by experience in the sense of epistemic injustice. Further, and importantly, we must set out why this is a systemic problem and not a failure or culpability on the part of the clinicians or academics party to the coproduced research. Notwithstanding further discussion, the present picture of coproduction is one which is strikingly different from the characterisations of this research methodology with which I began this thesis: it is not, or does not presently appear to be, an equitable research methodology.[116]

3 – Epistemic oppression

How then, might we make sense of (i)-(iv) above in a way which does as promised, and makes sense of the inability of experts by experience to present sufficient epistemic challenge to commonly accepted views to bring about a change in those views? Importantly,

---

[116] I should note here, again, that there *are* examples of coproduction, even within the domain of mental ill health or psychiatric practice, which have been done well, and have been viewed positively by all parties. My arguments here are not intended to detract from those positive instances, rather, in thinking about coproduction and potential for epistemic harms, as I'll briefly explore towards the end of this thesis, we would do well to consider *whether* coproduction is always the best methodology, and to acknowledge that there are very many kinds of alternate methodology we could utilise. On this, see especially: Harcourt and Crepaz-Keay (2023); Oliver, Cathari and Mays (2019); Steen, Brandsen and Verschuere (2018); Williams et al. (2020).

recall from Fricker’s work that in order that this be considered an epistemic injustice, broadly speaking, any denial of epistemic agency (by, in this case, refusal to receive testimony as it is presented) must be both harmful and wrong. Whilst I extended this to also require that there is reason to suppose experts by experience do have knowledge which fails to be received as credible information, that this condition was met, I argued for in Chapter 2. The wrongful element of the picture as I have painted it thus far, then relates to the following features:

Holism as improving research acceptability and generalisability (Holism)

The expertise that experts by experience possess is both arrived at in a different way, and amassed from a different vantage to clinicians. It is purported that coproduced research, because of the bringing together of a range of experiences, can give a more well-rounded view of the research topic. A central part of the ability of coproduced research to do so, is the inclusion of knowledge and voices not ordinarily heard in research. Denial of the legitimacy, or the content, of the contributions of experts by experience, thus undermines this potential in research outputs.

Collaboration and power equity (Collaboration)

Coproduction necessarily requires that all parties are treated as co-researchers, with traditional hierarchies flattened, and all agents treated as equal research partners. This will have been explicit in the invitation extended to experts by experience, and thus non-adherence to this promise is wrong, insofar as it means the invitation appears in bad faith.

We might, though, wonder what makes the instances I discuss *harmful*, epistemically speaking. Whilst I think it is clear that there is perhaps also a moral harm at play too, I set that aside for now, focussing solely on the epistemic nature of the phenomenon at hand. And that requires that we consider how experts by experience are harmed in their capacity as knowers *qua* epistemic agents. This, I suggest, can be neatly explained by Kristie Dotson's work in 'Conceptualizing Epistemic Oppression' (2014). There, Dotson introduces the concept of *epistemic exclusion*, explaining it as follows:

> "Epistemic exclusion… will be understood as an unwarranted infringement on the epistemic agency of knowers"
>
> (Dotson, 2014: 115).

This alone does little more than the paragraph which precedes it, in terms of explaining *how* this constitutes an epistemic injustice – we already know from Holism and Collaboration that there is something *wrong*, which we might understand as 'unwarranted', in denying, or applying our own interpretative lens to what experts by experience tell us. However, Dotson's definition of *epistemic agency* gets us a little further in our analysis. This, she says:

> "refers to the ability to utilize persuasively shared epistemic resources within a given community of knowers in order to participate in knowledge production, and if required, the revision of those same resources"
>
> (Dotson, 2014: 115).

What is especially striking here is the mention of knowledge production, as after all, that is the very point of coproduction (and indeed, research in general). Dotson of course is not speaking specifically about either research or coproduction, but I think, given discussions of her contributory injustice framework in Chapter 3, is getting at broader expansions of knowledge that we have as communities of knowers. The focus, insofar as knowledge production requires expanding on, changing, updating, or developing our understanding, remains particularly relevant for our purposes here. Note too that Dotson makes mention of *shared epistemic resources*, which, she considers as being contained within our epistemological systems. These systems, though not identical to instituted social imaginaries, she describes as containing all of the elements I discussed as being part of shared hermeneutical resources, and those, as we have seen, are shaped by the instituted social imaginary (Dotson, 2014). As such, in referring to 'epistemological systems' in what follows, I mean to refer to both those norms and accepted ways of knowing and acquiring knowledge (the instituted social imaginary) *and* the shared hermeneutical resource (epistemic resources, for Dotson) which are operative within a given group. And in the coproduction context, where traditionally power and control as well as sociopolitical privilege have been held by academics and clinicians more so than individuals with mental ill health conditions, I think it fair to surmise that those epistemological systems are skewed in favour of that more dominant group in the coproduction team. Lastly, in relation to the defining of epistemic agency is reference to 'revising' epistemic resources, or having the ability to do so. And this is precisely where we had arrived, as a challenge for coproduction at the end of s2.2. I have established that, often, experts by experience cannot revise, or create sufficient epistemic friction to prompt the revision of, those resources, and that their attempts to do as such is where problems arise. What we can now use Dotson to claim then, is that this together constitutes *epistemic oppression:*

> "epistemic oppression refers to a persistent and unwarranted infringement on the ability to utilize persuasively shared epistemic resources that hinder one's contribution to knowledge production"
>
> (Dotson, 2014: 116).

The question that remains is, is this a preferable view to those set out in Chapter Three? I've alluded to requiring a picture of the epistemic injustice in cases such as these which can give us a systemic understanding of such harms, as opposed to focusing at the level of individual interaction. Following Medina (2011), I am inclined to think that the better able a theory is to explain the broader picture, the better. I have also considered the role of stigma as affecting the credence typically extended to statements made by experts by experience, and suggested that this might get us some of the way to an understanding. As Dotson explains, some individuals have their credibility lowered across the board, such that they are "routinely deemed less credible" (2014: 124), even when they should be assigned high, or equal, levels. And as Scrutton has shown, mental ill health is an identity or characteristic which is primed to result in credibility-deficits in *all* interactions, not just those pertaining to one's illness or distress (Scrutton, 2017). There is little reason to suppose that without concerted remediation efforts, such credibility assignments will shift of their own accord; this may be particularly more so if one is attempting to convey a point of view which seems contentious. Following Cynthia Townley (2003), I think we could well understand the folk-position that mental ill health means that one just is deemed less credible, or reliable as an informant, as a version of the curse of Cassandra, whereby even if experts by experience were always speaking entirely truthfully (in an objective sense of the word 'truth'), their social identity and all that goes along with that would serve to render them entirely *in*credible (Townley, 2003). All of that said, however, if credibility deficits were the only feature of this case, then not only would we have done perfectly well with Fricker's testimonial injustice as an explanation of the central cases I'm concentrated on, but pointing out how stigma is repeatedly undermining expert by experience attempts to meaningfully participate would, I hope, be sufficient to motivate a behavioural change in the credal assessments at play. This revision of credibility assignments, within the instituted social imaginary, based on an acknowledgement that, to date, research practice had not been equitable, could be easily achieved without much change in the instituted social imaginary, for example as a conscious effort on the part of the traditional research team.[117] There would, of course, still be a degree of shifting of practice required, but the epistemological systems relied upon could accommodate such shifts, without prompting large-scale revision of that system. And though this may strike you as a dubitable claim, I argue it is plausible that having had the biases one is relying upon made salient, we might see a reduction or effort to correct those. The emergence of literature which indicates that implicit biases (in this case, unconscious credibility assignments) can be revised if called out, at least seems to indicate that this is so.[118] And, if 'fixing' the ways we assign credibility would suffice to remedy the situation, or perhaps better, *could* suffice to remedy the situation, then Dotson argues the injustice *qua* epistemic oppression isn't actually epistemic at all, rather it's entirely reducible to our sociopolitical landscapes. It may well manifest in epistemic ways – by undermining the credibility of some knowers and thus engendering epistemic exclusion – but there is nothing uniquely epistemic about it.

3.1 – Epistemological resilience

As I argued in 2.2. though, there is also the issue of biased shared hermeneutical resources at play, and manifest active ignorance on the part of the traditionally qualified 'experts' in the research team. This, I follow Medina in claiming, can give rise to meta-blindness. Now, I argued in the previous chapter that I do not think hermeneutical injustice explains the phenomenon upon which I am focusing. Neither do I think that a conceptual 'lack' on the part of experts by experience explains the lack of uptake their statements receive. As such, I

---

[117] This, for Dotson would be considered a first-order epistemic oppression which she explicates by presenting an extended version of the *Allegory*. I do not think it necessary to recreate her depiction of the *Shadowlands* here.

[118] See, for instance: Gopal, et al. (2021); Vela, et al. (2022) and Lindvall-Östling (2024).

will not pursue further discussion of whether there exists a conceptual lacuna. I have noted, however, that within the shared hermeneutical resources, which are surely skewed towards the clinical and academic members of the research team, there will likely be little room for views which challenge psychiatric medicine. Narratives presented by experts by experience which argue against the clinical necessity of psychiatric intervention (or detention), question its fundamental benefit, or clinical legitimacy, are then likely in conflict with the content of those skewed resources. Narratives presented by experts by experience that attempt to present a view incongruent with accepted understandings, such as the examples just given, are where we've seen problems arise. This, I want to say, is because of the central feature of our epistemological systems: they are incredibly resilient.

Resilience of our epistemological systems, relates to the degree of contradictory, or incongruent information which can be absorbed by the system without destabilisation (Dotson, 2014). Recall that meta-blindness, and the seeking of epistemic friction are central to virtuous epistemic practice for Medina (2011, 2013). Both of these concepts indicate that there is a large amount of competing information that our epistemologies can make sense of, before we reach a place where our epistemological systems themselves appear inadequate for the task which is presented to us. Reaching such a point may be incredibly difficult, as Dotson and others explain. This is because we are so reliant on our epistemological systems, and our hermeneutical resources to "make sense of the world" (Dotson, 2014: 122). Given that such importance is placed upon the stability of these systems, we might begin to see that resilience is a necessary feature of the backdrop, or pre-theoretical concepts that underlie our abilities to know and to reason. A system with no resilience would be in a constant state of flux or disarray, with every new bit of information having the ability to serve as a catalyst for complete revision of our epistemology. Epistemic friction, as Medina has described it, encourages prudent epistemic practice on the part of agents, as it allows new information to be assessed, and a constant monitoring of the sufficiency of ones' epistemic boundaries to be undertaken; such monitoring, however, is undertaken using the operative epistemological system, and the hermeneutical resources one possesses, and as such, identifying an insufficiency might prompt something of an epistemic crisis. However, reasoning from within one's epistemological system, using hermeneutical resources developed in accordance with the rules of that system, and yet using both of these to appraise the entirety of one's operative system is a sort of meta-level analysis which is practicably extraordinarily challenging to even set out.[119] As Dotson explains, drawing on Bartunek and Moch's (1994) organisational change literature, encountering an insufficiency in ones' epistemological system and identifying it correctly as an insufficiency would almost require:

> "experiencing the impossible as possible and, correspondingly, viewing the limits of one's epistemological systems that designate the possible as impossible"
> (Dotson, 2014: 132).

I do not, therefore, think that many of us ought to be unduly concerned about reaching such a crisis inducing point, as the expectability of identifying the insufficiency I have argued we would need to identify, is likely reliant upon a level of abstraction that I think most of could not achieve. But, Dotson notes, a recognition that the boundaries of ones' epistemological system mean the system itself is ill-equipped to deal with a particular task, or perhaps even that the system no longer suffices for ones' purposes. This would require a sufficient degree of epistemic friction to be generated that there is a disturbance of a necessary magnitude

---

[119] This is, if it is actually possible at all.

created for the limits to be laid bare in undeniable ways (Dotson, 2014: 132). And, because of the meta-level of this work, she argues, such disturbance can only be created if we also possess relevant levels of epistemic power. *Epistemic power*, as distinct from, but related to credibility or levels of credence one possesses, relates to:

> "relations of privilege and underprivileged afforded via different social positions, relevant resources and/or epistemological systems with respect to knowledge production"
>
> (Dotson, 2014: 125).

An individual with a high level of privilege, relative to a particular project or position of inquiry, Dotson suggests (2014: 126) will not easily abandon that privilege. To do so would be to give up the ability to shape and change shared hermeneutical resources, and perhaps, to even require the bringing about of changes to the epistemological system itself. What discussions of resilience above have shown, however, is that generating a sufficient degree of epistemic friction to cause such a realisation, even for those in positions with the epistemic power to do so is incredibly challenging. This could be as a result of self-interest, or, because the level of abstraction required to cast sufficient doubt on the efficacy of our epistemologies whilst using those epistemologies is incalculable.

3.2 – Putting the pieces together: exclusion of experts by experience as epistemic oppression

Considering all of this together then allows us to piece together a picture of what I think might be plausibly at play in coproduction when things go awry. Particularly, I am interested in giving an explanation which gets us closer to understanding *why*, as I said in (iii) in section 2.2., "in order to affect advancements in dominant understanding, information that experts by experience give must either cohere with commonly accepted information, or must be presented by a highly-credible individual such that the epistemic friction generated is sufficient to lay bare the limits of the instituted social imaginary." As a first pass, an explanation of this might go something like:

(a) In virtue of sociopolitical histories which give rise to stigma, experts by experience, because of their mental ill health, are assigned credibility deficits relative to their academic or clinical research counterparts;

(b) Testimony that experts by experience give, *t*, which could not be assimilated into the epistemological system and shared hermeneutical resources without significant revision of those same resources, cannot, because of (a) bring about momentous enough occasion to highlight the insufficiency of those resources, because;

 (b^1) The epistemological system which governs research into mental ill health is both exceptionally resilient and protective of the histories of psychiatric medicine.

 (b^2) *t*, if accepted, would cause a disturbance so significant that it would affect the legitimacy of our current approach to mental ill health, in clinical terms. And so:

(c) Clinical and academic experts, who have more epistemic power, *qua* privilege, and whose shared hermeneutical resources preclude *t* from being understood in a way coherent with those resources, must either interpret *t* in ways coherent with the epistemological system, or their shared hermeneutical resources, or find ways of otherwise dismissing *t.*

(d) Experts by experience are then epistemically excluded, insofar as they are unable to contribute their knowledge to those shared hermeneutical resources, in ways which might shape the knowledge produced by a research project.

(a)-(e) taken together, then, help us to begin to understand how epistemic oppression as a framework is especially apt to explain what might be happening in the sorts of cases I am considering. It also allows us to understand why a credibility redress alone would not suffice to prevent experts by experience from drawing on, or, where required, changing, shared epistemic resources. Our epistemological systems are too resilient for individuals lacking epistemic power to generate sufficient epistemic friction to call into question the sufficiency of the system for the task at hand. And, the sorts of knowledge that I am arguing here are being excluded, are largely those which are negatively valenced with respect to the efficacy, legitimacy, or benefit of psychiatry.[120] Otherwise, as we've seen, experts by experience merely affirm what is already believed, perhaps casting a new light on the topics, but nonetheless in ways which do not challenge the content of the epistemological system. Contributions are only rendered challenging where the content of such contributions attempts to challenge those normative, value-based, beliefs relating to what is, or is not, an illness, and perhaps where the role of medicine should start, and end.

This is not altogether a surprise. As Dotson herself says, testimony of the most marginalised groups often does not "afford a momentous enough occasion to catalyse the appropriate alterations within shared epistemic resources" (2014: 130). If *t* were afforded a high credence, it would cast light on the insufficiency of the shared hermeneutical resources, or our present understandings of mental ill health, and the ways in which the operative epistemological system maintains such insufficiency. More simply: if *t* were accepted as something we ought to believe, but could not be accommodated based on our ways of

---

[120] There will of course be dismissal of expert by experience view which is not trying to assert positions like this, and those I think could be explained by looking at credibility deficits and epistemic power. I'm inclined to think that such instances could be successfully resolved without a requirement to revise the entire epistemological system.

reasoning, then necessarily we would become aware of an issue in those ways of reasoning which preclude its accommodation. (a)-(e) help us to unpack how the situatedness of experts by experience, as a socially marginalised group of persons, along with the biased shared hermeneutical resources, unequally influenced by those with more epistemic power, *and* the resilience (or self-levelling nature) of our epistemological systems, work in a tripartite fashion to preclude the possibility of expert by experience narrative being able to change those resources. The resilience of the epistemological system, and the inability of academics and clinicians to detect such resilience and see its limits, is too great, and so sufficient friction to lay bare its demerits cannot be generated by experts by experience.

3.3 – Addressing the obvious objection: credibility revisited

Whilst I think this a plausible understanding of what goes awry, and why, in some instances of coproduction, I would be remiss not to address the most obvious criticism of (a)-(e) that immediately springs to mind. (a) relies upon credibility deficits assigned to experts by experience. Could it be that credibility could itself be the sole cause of the inability of experts by experience to shape or change shared hermeneutical resources, giving rise to the injustices at play? If so, we may do as well to understand these in a distributive sense. That is, as an unfairness in the way in which credibility has been apportioned amongst the group. And this is certainly an objection to the view I have given which David Coady (2012, 2017) would argue for, I suspect. Coady claims that we ought to consider credibility as a finite good whose distribution can be unjust, because it is a ‘good’ which there is the possibility of competition over (2017: 66). And so, one way to argue against the picture of epistemic oppression I’ve painted above would be to argue that the credibility assessments taking place in (a) are unjust – which I think it fairly uncontentious that they are – and that there is thus an injustice in our distributions of a limited good, remediation of which would remove the injustice. There are a few things to say about this.

First, Miranda Fricker denies that credibility is a finite good, or is a good about which there is puzzlement. She argues that:

> "credibility is a concept which wears its proper distribution on its sleeve. Epistemological nuance aside, the hearer's obligation is obvious: she must match the level of credibility she assigns her interlocutor to the evidence that he is offering the truth"
>
> (Fricker, 2007: 19).

And, as such, injustices with respect to credibility assignment arise from faulty assessments of reliability of a speaker: this is the premise of testimonial injustice. Further, I'm sympathetic to Fricker's claim that context matters for credibility assignments, and think the discussions of expertise in Chapter 2 show that credal assessments are not absolute, and may (and should) differ and change with respect to a domain. I also, *pace* Coady, think that our credibility assessments in any given credibility economy must be undertaken contrastively. Oftentimes, it is not the case that I deflate an individuals' credibility *simpliciter*. Rather, if some utterance *t* is presented, and I am deliberating about whether I should believe it, or disregard it, and thus whether I ought to assign a high or less-high credal value to the speakers' assertion, I consider *t* in the context of my instituted epistemological system: that is, is *t* in keeping with other beliefs I hold within the same domain. If no, then (as we've seen above) epistemological resilience determines that I should carefully consider whether *t* gives sufficient cause to revise the hermeneutical resources upon which I rely, unless I assign a greater level of credibility to the speaker who asserts *t* than to the individuals or resources that have given me some non-*t* congruent beliefs or concepts. Credibility is, by its very nature, contrastive (Medina, 2011: 20-21; Dotson, 2014: 126).

Credibility, as I've argued, also cannot be the only, or the central, feature of an explanation for the exclusion of experts by experience, principally because coproduction depends on equity (or parity) of control and influence over the research. As sceptical as I am that such equity or parity is achievable – as I'll discuss more in a moment – I said in Chapter Three that in the absence of equity or parity of power, the research could not be considered coproduced at all. You could still make the claim, of course, that credibility is finite, and thus the distribution of it is what has given rise to an injustice – a distributive injustice – but I think you could not both make that claim and say that your research project had been coproduced, as the premise of power-sharing is enshrined in the definition of the methodology. Such power sharing would, by necessity, require the possibility of beginning from a place of equal credence afforded to all individuals. Further, as I presented (a)-(e), reliance is on both credibility, and epistemic power, not just credibility. Discussions of shared hermeneutical resources and the bias inherent within them suggests that even granting equal credence to expert by experience contributions would not remedy any more than (a) above, as they would still (positionally, in a sociopolitical sense) lack epistemic power, even if they had equal power within the research team. Attempts to work within the epistemological system operative, then, would still be reliant upon those biased hermeneutical resources, which would still not leave room for their contribution. It is, I think, possible that a research team *could* try to give over equal control, and grant credence to, experts by experience within a coproduced project, and that the epistemological systems would still remain so resilient as to render their contributions *in*credible.[121] Explaining why this is so, I will come on to in Part Three of this thesis.

Lastly, we might also note that whilst parity of credibility is central to coproduction (when done properly), this does *not* mean equal credibility in each and every interaction. As my discussions in Chapter 2 also note, expertise is domain-specific, and nuance-sensitive, and so whether one party in the research team or other should be given a higher credal assignment at any given moment will depend upon the subject in question: I shouldn't believe an expert by experience about the pharmacological requirements of intra-muscular anti-psychotic suspensions any more than I should believe an academic or clinician with respect to the lasting phenomenological effects of having received such an injection. The contrastive nature of credibility requires that for each and every piece of information, I must assess whether that new information is likely right, and if it could plausibly be so, whether I can confidently take the word of my interlocutor as possessing a relevant amount of credence.[122] Credibility simply cannot, and, further, should not, be distributed equally all of the time as this would lead to epistemological disarray in much the similar way as an epistemological system which lacked the capacity for robust resilience. As such, an understanding based in distributive injustice, I think, not only fails to explain (a)-(e), but would serve to also mislead with respect to the requirements for credence sharing. As Fricker says, credibility should be given in line with the expertise one has relative to the discussion one is taking part in (Fricker, 2007: 19). Even within coproduction, we ought not to mistake this for a requirement

---

[121] Where those views are so opposed to those of psychiatric medicine.

[122] Whilst this raises the possibility that one could be right, and present true information entirely by accident (thus potentially being perceived to have a level of credence that you in fact lack) which I find interesting, it falls beyond the scope of this thesis to explore this further.

for equal credence in each and every discussion. What I have indicated here is that there is reason to suppose equal credence is not given in many such discussions.

3.4 – The role of epistemic power: academic norms and expertise of the right 'kind'

A further criticism of (a)-(e) which I also feel must be addressed again is that, you might think, credibility and epistemic power just are the same thing. Or at least, if we prevented credibility deficits from being assigned to experts by experience, you might be of the view that this would give experts by experience the epistemic power they might need to bring about changes, or even show the insufficiency of, the epistemological system. This, I think we can answer by returning to explore the role of epistemic power, particularly as it relates to the norms of the academy.

Dotson says, that to redress third-order epistemic oppression (which is just epistemic oppression which in part can be traced to the resilience of the epistemological systems themselves), those in more epistemically powerful positions:

> "will need to extend extraordinary amounts of credibility…[to those with less]. They must also be open to radical conceptual revolutions in the fact of, quite possibly, profoundly insufficient shared epistemic resources. But they must also, and this is the hardest part, grapple with the resilience of their epistemological systems to grasp what portions of their overall epistemic life ways are thwarting robust uptake of the testimony of… [those with less epistemic power]. As a result, what makes third-order epistemic oppression an irreducible epistemic oppression is not the absence of epistemic power. Epistemic power will absolutely exist as a problem for third-order changes"
>
> (Dotson, 2014: 132).

Overhauling the entire epistemological system, as we've seen would be necessary to address the limits of that system which give rise to epistemic oppression, would require that existing social relations, including the determination of who is privileged and who is less-so, be similarly reconsidered (Dotson, 2014). Who can be treated as an individual that, *ceteris* *paribus*, we should listen to above others, then is in some ways contained within the fabric of our social imaginaries insofar as they govern our ways of knowing. This is important here because whilst credibility conferrals could presumably be changed without much overhaul of epistemic practices – i.e. by deciding that this particular individual has historically been subject to bias, but on balance is likely speaking from a place of relative expertise, and thus should be believed – what should happen in instances where that individual's assertion is incongruent with other widely held beliefs will be determined on who has the epistemic power to call into question the sufficiency of the epistemological system. This, as we've seen, is those with more epistemic power, and I've argued that experts by experience do not stand in a position of such privilege. Thus, they are not in a position to shift or shape the system itself. So, for our present picture, if *t* as asserted by an expert by experience, is understood as being something we should take seriously, then it falls to the academics and clinicians (at least as I construed it in (c) in section 3.2.) to determine what should be done with *t*, as it conflicts with our widely accepted knowledge as instituted in our shared hermeneutical resources. But why is this so?

Venkatesh Vaditya, in *Social Domination and Epistemic Marginalisation* (2018) argues that within society:

> "dominant groups establish a hegemonic hold… primarily through successfully positioning their epistemic privilege and dominant worldview as the most legitimate and natural way to view the world"
>
> (Vaditya, 2018: 273).

Academia, and those who work within it, are, I think, one such dominant group. As Vaditya argues, our accepted paradigms of research practice, privilege ways of acquiring knowledge and epistemic practices, which I think, are at odds with social conceptions of mental ill health. Within research, objectivity, rationality, and impartiality are given central importance, and often room is simply not made within our academic research norms for perspectives motivated by anything deemed less than scientific (Vaditya, 2018). This includes knowledge gained by experience which was not acquired in a replicable, or controlled way (Brown and Strega, 2005). These normative understandings of research are not only instituted within the process of doing research itself, but also within the academy, the norms associated with academic practice, which include dissemination of research, ordinarily in the form of publications, and in the impacts that these activities have upon one's academic reputation. As Goldman notes:

> "greater scholarly or scientific credit redounds to authors who publish in better journals. Such credit in turn gets translated into tenure, promotion and salary increases… scientists and scholars are given better incentives to do better work"
>
> (Goldman, 1999: 178).

As such, clinicians and academics have a vested interest in a continuation of present research practice, such that their prestige is bound up within it. Because 'science' proper, is often not considered subjective, or anecdotally inclined, epistemic power is maintained by appeal to objective knowledge, and peer-appraisal. Academics, as the traditional 'knowers', who have worked for years to hone and develop a specialism within a particular domain will be ill-motivated to dismantle or show as insufficient the epistemological systems which have accorded them with a particular level of scientific expertise. To do so would be to give up their position as epistemic expert in the domain they have studied and worked so hard to attain a position of privilege in. And so, if you recall my discussions around how 'expertise by experience' should be understood, it may be that in scenarios where experts by experience disagree with established views in ways which undermine previously established scientific findings, the research team may choose – or feel compelled – to understand expertise by experience as a signifier for contributions which, though derived from lived experience, are to be treated as anecdotal, as opposed to scientific and factual. The epistemic privilege afforded to academics and clinicians, as those learned individuals whose lives have been dedicated to learning and the pursuit of knowledge, simply could not make room, based on Vaditya and Goldman's remarks, within operative epistemological systems for entirely new conceptions of mental ill health, particularly not if that making room is on the basis of subjective, anecdotal, testimonies. I suspect, even if one aimed to *really* recognise the expertise of experts by experience, as I have argued for it, that all of the factors I have alluded to here, would still mean epistemic power was retained by the academic and clinical parties. After all, they are the ones who hold the research grants, who are deemed 'qualified' to undertake research funded by knowledge generating institutions, and whose expertise has likely led to the commencement of the coproduced project in the first place.

In Part Three of this thesis, I will go slightly further than this, and illustrate that we might even say in virtue of their mental ill health that experts by experience in some way are seen to transgress the norms of objectivity and rationality I noted above, at least based on folk understanding. But for now, what I think we can say, is that experts by experience face a double-bind of sorts.

4 – The double bind faced by experts by experience

Based on what I have said, then, experts by experience do possess expertise, and that expertise rests on their having first-hand experience of mental ill health, contact with the psychiatric medicine system, and awareness of the socio-political-personal implications of this. However, based on their social positionality, their credibility is deflated, even if marginally so. And notwithstanding credibility, experts by experience are also not scientists, or scholars, in the traditional senses of those terms, and so do not have the same epistemic power, in the context of research, as those who are more traditionally 'qualified'. Despite invitations to take part in research precisely *because* of their lived experience, then, that experience both undermines their credibility, *and* is not of the right 'kind' to be taken seriously in an academic sense. The derivation of the knowledge that experts by experience possess as being grounded in experience, renders it subjective and non-scientific.

Even if, as I think is likely often the case, the clinicians and academics who are involved in coproduced research – and perhaps who chose this as a methodological approach – *want* to take seriously the experts by experience, they too are situated within the epistemological system which privileges both their positionality, and their knowledge. Even if experts by experience then had high credence afforded to their testimonies, I think it unlikely because of the epistemic power relations contained within the epistemological system, that this would prompt a revision or recognition of the limits of that system. This, I argue, is because the norms of academia, psychiatry, medicine, and 'normal human function' are contained within that system. And as I've construed the problem cases, they arise primarily when experts by experience are attempting to convey knowledge which calls into question the legitimacy of those norms and values.

Epistemic power then, is a problem, but so too is the almost looping mechanism in effect within epistemological systems themselves. This, Dotson explains as follows:

> "the very resilience of the system may thwart one's ability to make significant headway in becoming aware of the limitations of one's epistemological system by only revealing what the system is prone to reveal, thereby reinforcing the idea that one's system is adequate to the task, when one is actually stuck in a vicious loop"
> (Dotson, 2014: 132).

This will be an important point, to which I will return.

The experts by experience may well, in a coproduced project, have recognised that the current research paradigms and methods do not, and cannot, make room for their knowledge, as that knowledge may not be able to be contained within the bounds of the epistemological system as it is currently arranged. However, because they lack the epistemic power to bring about a seismic shift in that system, even if astute and conscientious assessments of their credibility have been undertaken, only those in positions of epistemic power would be able to prompt a revision.[123] This, similar to Dotson's recreation of the *Allegory* is often the case – the most marginalised within an epistemic community are often able to see the insufficiencies within their epistemologies insofar as they fail to reflect the world as they know it (Dotson, 2014). Irrespective of this awareness, though, they remain powerless to do anything about it, because they lack both the credence and the power that would be required to prompt a shift. In most all cases then, I suspect that experts by experience will not be able to bring a revision to either the shared hermeneutical resources or to the instituted social imaginaries: this is where the subversion, dismissal or interpretation of their testimony arises.

Based on this discussion of epistemic power, we might slightly revise the explanation provided in 3.2., with additions italicised, to give us something like the following picture:

(a) In virtue of sociopolitical histories which give rise to stigma, experts by experience, because of their mental ill health, are assigned credibility deficits relative to their academic or clinical research counterparts;

---

[123] This represents one of the central challenges that activists from critical psychiatry, anti-psychiatry, and Mad Studies have levelled at coproduction. Farr (2018) for instance argues that coproduction is not ever designed to challenge psychiatry as an institution, and Penney and Prescott (2016) go further claiming that the invitation to coproduce is a process of co-opting "survivor knowledge" in an attempt "to absorb or neutralize a weaker opposition that it believes poses a threat to its continued power" (2016:35). This is not a view incompatible with the explanation Dotson gives regarding the self-interest the epistemically privileged group might have in retaining that privilege, though it paints it in a much more pernicious light.

(b) *Experts by experience, again because of their mental ill health, are members of a marginalised group, who have less epistemic power;*

(c) *The norms of scientific inquiry, contained in our epistemological system, privilege objectively arrived at research conclusions, produced by well-reputed experts.*

(d) Testimony that experts by experience give, *t*, which could not be assimilated into the epistemological system and shared hermeneutical resources without significant revision of those same resources, cannot, because of (a) and (b) bring about momentous enough occasion to highlight the insufficiency of those resources, because;

  (d^1) The epistemological system which governs research into mental ill health is both exceptionally resilient and protective of the histories of psychiatric medicine.

  (d^2) *t*, if accepted, would cause a disturbance so significant that it would affect the legitimacy of our current approach to mental ill health, in clinical terms.

  (d^3) *Such disturbance would arise as a result of non-scientific, subjective experience, and not from a position of replicable, scientific, objectivity (thus contravening (c)).*

  And so:

(e) Clinical and academic experts, who have more epistemic power, *qua* privilege, and whose shared hermeneutical resources preclude *t* from being understood in a way coherent with those resources, must either interpret *t* in ways coherent with the epistemological system, or their shared hermeneutical resources, or find ways of otherwise dismissing *t.*

(f) Experts by experience are then epistemically excluded, insofar as they are unable to contribute their knowledge to those shared hermeneutical resources, in ways which might shape the knowledge produced by a research project.

This allows us to then say, by way of conclusion to these very loosely constructed premises that: deference to the clinical and academic experts, who have more epistemic power and who are not seen to be speaking from a place of subjectivity (and perhaps irrationality) and who hold the view that not-*t*, is required, to maintain the epistemological system in its present form. Experts by experience may very well possess kinds of expertise, rooted in the experience of having had mental ill health. However, such experience is not, epistemically speaking, robust enough to allow for challenge to the current way things are. In a research context, if those with the epistemic power to prompt revision of the epistemological systems, using habits of reasoning entrenched within the instituted social imaginary, cannot see that there is an alternative to the way in which they have made sense of the expert by experience testimony, it cannot be taken seriously. Even the most well-meaning and good-intentioned clinician or academic, will be likely to interpret, shape, or understand the expert by experience's view in a way which coheres with what they already 'know' to be proven.[124] This is not because they mean to undermine the expert by experience, but because the expert by experience's knowledge is rendered nonsensical by our established ways of sense-making. This, then gets us to an understanding of why *epistemic exclusion* as Dotson has explained it, is so apt to explain this phenomenon. The inability to use and shape those dominant, persuasively shared hermeneutical resources persistently undermines the ability of experts by experience to have their testimony received in ways which advance knowledge production in a user-informed way. What I find especially appealing about this view, is that it allows for the possibility of positive intention on the part of those with epistemic power, and

---

[124] Again, Mad Studies scholars would challenge the charitable position I defend here with respect to the lack of culpability of the academic and clinical members of the research team. Joseph (2022) for instance has argued that appeals to well-intentioned, but oblivious to the possibility of alternative views, is a poor justification for the perpetuation of "ongoing forms of transnational denial and colonial violence" (2022: 136).

even for high credal value to be assigned to expert by experience views – the subversion or interpretation of those views, in a way similar to 'they surely must have meant that *s* when they uttered *t*', need not be accompanied by any culpability. This does not mean it could never be based on malintent, rather that most exclusion can be explained by the resilience of epistemological systems. Even when alternative ways of making sense are known, alternative practices are hard to conceptualise and even harder to bring about from within an instituted system. This too allows us to make sense of epistemic oppression as an epistemic injustice on a systemic level: it is surely wrongful, and harmful, in the ways it undermines efforts of experts by experience to contribute their views, but it elides the efficacy of arguments for simple credibility redress. Our epistemological systems *qua* social imaginaries are robust, and well established, and the juxtaposition between psychiatric illness and robust scholarly thought cannot be easily assimilated within that system.

4.1 – A remaining objection: is everything an epistemic oppression?

If what I have set out in section 4 is accepted then, I've established a way of making sense of apparently *all* dismissal of expert by experience testimony as an epistemic oppression. By this I mean to say that there is presently no means I have given of deciding whether, or even if, there are situations in which we might be right not to change research course, based on what experts by experience say. Appeals to power, credibility, and system resilience apply in an almost acontextual way – we could use this understanding to craft a story whereby almost any expert by experience's negative experience within a coproduced research project in mental ill health could be framed as an epistemic exclusion *qua* epistemic injustice.[125] And

---

[125] Insofar as 'negative experience' here is understood as situations like those I've described, where the 'knowledge' that experts by experience seek to have taken seriously so as to shape the direction of future

recall, that was precisely my concern with the accounts of epistemic injustice as they pertain to psychiatry with which I began in chapter 1. We are often quick to understand something as an epistemic injustice as it pertains to a marginalised group, without adequately considering whether it is right to do so. The epistemic condition – 'do they know?' – helps, insofar as it removes the opportunity to make such claims when the individual with lived experience is simply unqualified to speak to a particular topic. They do not, in such instances, have knowledge that we would be right to heed.

Even having done the work of introducing and defending the knowledge that experts by experience might have, as a legitimate kind of expertise, I worry the issue here is not prevented. This is because it is also possible that an individual who does indeed possess expertise, which is derived from their experience, holds a view or has values which we should (perhaps ethically) not seek to have shape shared hermeneutical resources, or prompt revisions to our epistemological systems. Without wishing to jump ahead – as I'll discuss the potential tensions that arise in relation to related questions in Chapter 5 – one example of where we might worry about incorporating views that are incongruent, could be in relation to the use of the Mental Health Act, to detain individuals who are likely to take their own lives. It's possible that an expert by experience who has been 'sectioned', and has since undertaken years of their own learning, can speak to the many problematic ways in which Mental Health Act assessments can be carried out, *is* qualified on the basis of her experience to coproduce research relating to the use of the Act. However, it's also possible that her view is that we should *never* detain individuals against their own will, and that suicide (which we might think could have been prevented) just is sometimes an unfortunate

---

research, this is not just a consequence of my argument, but is something scholars in Mad Studies have begun to argue for. See, for example: White, 2022; Beresford and Russo, 2022.

consequence of distress, and further that it is in fact a choice that individuals should be free to make.[126] In this kind of scenario, I think it difficult to argue that we should allow her view to change clinical recommendations; a *laissez-faire* approach to suicide is certainly not currently condoned within approaches to psychiatric medicine. But, the tension arises, even with the work done in Part One of this thesis, because the expert by experience *is* both experienced in having being detained, and has amassed a body of knowledge relating to all of those domains of related knowledge that Dumez and L'Espérance (2024) set out in their discussions of expertise by experience. She rightly can speak to the topic, but one would argue her view should not be heeded. Why not, however, is a thorny issue.

One route might be to say that where there are matters of significance as great as survival, the clinicians should always have the final view (which, as I've argued, would be exactly what tends to happen in such cases, anyway) to safeguard the interests of people presumed to lack (rational) capacity. Yet, as discussion of Tyreman's (2005) work demonstrated, this is to codify paternalism into coproduction – the very opposite of its aim. However, to understand this particular case as an epistemic oppression too seems misguided, it doesn't seem 'wrongful' to prevent this view from shaping future directions of research or treatment recommendation.

We could instead attempt to appeal to a distinction between the 'views' of experts by experience, insofar as they have personal opinions about psychiatric medicine, preferred

---

[126] DuBrul (2014) for example says that mental ill health is a 'dangerous gift' akin to that possessed by Icarus, and that "At our depths we may end up alienated and alone, incarcerated in psychiatric institutions, or dead by our own hands. Despite these risks, we recognize the intertwined threads of madness and creativity as tools of inspiration and hope in this repressed and damaged society. We understand that we are members of a group that has been misunderstood and persecuted throughout history, but has also been responsible for some of its most brilliant creations. And we are proud" (p.259).

means of treatment, or legitimacy of psychiatry, and the ‘knowledge’ that they can contribute. The latter would likely need to be fleshed out, but might, for example, require that ‘knowledge’ be substantiated by more than anecdote or personal feeling. But without requiring scholarly research, and evidentially based contributions (which is just to say ‘objective’ or academic knowledge) it is hard to see how this line of argument could be pursued either. The very basis of expertise by experience is that it is based *on* experience, and is not reliant on one’s academic knowledge. Expertise by experience is not intended to be the same in kind as that of the academics on the research team.[127] And if that distinction was not doomed to failure on that front alone, it’s entirely plausible that someone so inclined *could* arm themselves with hundreds of scholarly citations from the literature now, from ‘survivor’ or ‘emancipatory’ research, relating to mental ill health, and still present the same view or challenge to the research team. Mad Studies, and disability rights activists alike have argued against forcing of mental ill health treatment. The question then becomes one of the acceptability of particular ways of viewing mental ill health, and this, I’ll argue in what follows, is where things become even more complex than I have already set out.

What we need then, is a way of demarcating responsible research practices, from those which perpetuate epistemic injustice. This is not an easy task. In Chapter 5 I will go on to say that there are a range of tensions that one must be able to reconcile in order to even begin to give an answer to the question of how such demarcation should proceed. These tensions,

---

[127] We could attempt an appeal to needing knowledge about experience which is presented on behalf of a collective. However, such a move would undoubtably generate intense criticism. As Jilian Voronka (2016) notes, it is a problem with the label of ‘experts by experience’ to begin with. Voronka claims that the concept requires a universalisation of one’s identity in ways which “belies the variances that our bodies carry, how we experience madness, and how mental health fields of power respond to us” (2016: 197). The very point of expertise by experience, in my mind, is not to require such a universalisation, but to bring a perspective informed by those unique perspectives one gains by doing or having some experience for oneself. This is precisely the issue with trying to make a distinction like the one I’m discussing here.

regrettably are not ones that I claim to be able resolve within the scope of this thesis. However, I'll also argue in Chapter 5 that the tensions as they currently exist, unresolved, show precisely why epistemic oppression is so apt to explain the epistemic harm in such cases: we cannot dismiss experts by experience by appealing to a lack of knowledge, as there simply is no stronger source of truth than that which is empirically supported. And empirical support, as I'll show, exists on both sides of these divides. But, both sides of the same debates cannot be held simultaneously in our epistemological systems, and thus the power possessed by the academics and clinicians will mean that in most all cases, it is the experts by experience who will be undermined as knowers.

The work in this Chapter, however, has not been to resolve such questions, but rather to give a theoretical explanation of one way we might understand dismissals of experts by experience as an epistemic injustice. I'm inclined to think that, in terms of the viability of this as an explanation, we need not show precisely when such injustices arise. In fact, this Chapter began with a promise to understand mechanistically how we might understand the dismissals of expert by experience testimony, as I have set them out. And such a mechanistic account I have defended. We need not, in this Chapter, settle the question of which cases we might need to explore in more detail.

5 – Concluding remarks

Where we have arrived at, is then a view which allows us to explain the epistemic injustice in play when experts by experience have their testimony subverted, dismissed, or otherwise interpreted by their academic or clinical co-researchers. As above, this will not be an applicable framework in all cases where individuals feel they have not been taken seriously, or have not been able to bring about the shift in shared hermeneutical resources as they had hoped. I do think, however, it will likely feature in many instances where experts by experience are contributing something which goes beyond, or contradicts, commonly held beliefs. As I have set it out here, *epistemic oppression*, as a framework applied to such situations, allows us to make sense of the manifest ways in which such injustices are systemic. That is, they operate at a system wide level, ubiquitous in research contexts. This, I've indicated, allows us to understand these kinds of experiences as an epistemic injustice, even in scenarios where we are confident that the research team intended to coproduce well. Further, I'm persuaded by Dotson's claim that epistemic oppression as set out here, does give us an understanding of what is uniquely epistemic about this injustice. Whilst the resistance of our epistemological systems to any information which contravenes accepted methodologies, values, or ways of being may well have their origins in sociopolitical structures, their instituted-ness, as part of our social imaginaries will remain. This would even be the case if step-changes in those socio-political attitudes were to occur, as such changes would take time, I suspect, to filter through to our epistemic habits and ways of knowing. Because of this resistance, I've also argued here, mere redistribution of credibility such that it was equally apportioned among the research team would not suffice alone to prevent epistemic oppression in these cases. Whilst credibility and stigma absolutely have a role to play, they are far from sufficient conditions for epistemic oppression.

Dotson's work, then, helpfully illustrates how complex and entrenched our epistemic lifeways are, and how challenging it can be to work in new and novel ways. Where I critiqued *testimonial injustice* as being focused at the level of individual interaction, epistemic oppression allows us to take a broader view, and to locate the inability of experts by experience to contribute new perspectives in meaningful ways to research on the whole. This, I think helpful, as we've seen the problems which arise when we consider every interaction as a quest for truth or belief. The view I have presented here leaves open the possibility that in every collaborative research project, sometimes our goal will be belief, sometimes it will be consensus building, and other times still, it may be opining on a particular subject – if the arguments I have given here are to be accepted, though, experts by experience will have a harder time contributing to such academic endeavours than their scholarly counterparts.

It is indubitable that this discussion paints the possibility of efficacious coproduction in a rather negative light. If, as I've indicated, and as Dotson has argued, third-order epistemic oppression is so difficult to even identify, because of those features of active ignorance, and the resilience of epistemological systems, it's not clear at the moment where space for coproduction *proper* could even be carved out. However, by examining the ways in which certain values are privileged above others in our epistemologies, and by setting out the tensions one would need to resolve to be able to resolve the problem case with which I ended this Chapter, I wonder if we might perhaps begin to understand more about what sorts of views – or better, how particularly held or embodied values and habits – may struggle to affect change in our social imaginaries and shared hermeneutical resources. After all, we *know* there have been instances of coproduction done well, and so it cannot be the conclusion of this thesis that it ought not to be undertaken as a research methodology at all. Rather, by understanding what values may, or may not be cornerstones of our social imaginaries, we might start to sketch an understanding of when including experts-by-experience would be fruitless, or when we would need to commit to an abandonment of our current epistemological systems to bring about new knowledge. To this, then, I now turn.

Summary of Part Two

Part Two of this thesis set out to explore which theory of epistemic injustice is best placed to explain the harms evident in coproduction which I set out in Part One. In the course of this thesis section, then, I have focussed on an attempt to explain such harms in a way which did not pre-judge malintent on the part of clinicians or researchers, who often express desire to include those with lived experience in their work. I also sought, as discussed in Chapter Three, a way of understanding the epistemic injustices at play at a systemic level – the harms I focus on here are not anomalous, or even rare, experiences, but rather seem common and prevalent in coproduction.

Without wishing to repeat any of the arguments from the preceding two Chapters, there are a couple of upshots, and conclusions that it is worth making salient before reading on. As Chapter Three demonstrated, there are many ways one could make sense of the ways that experts by experience can be undermined in their capacity as knowers. You may prefer any one of the views I dismissed, and may feel that any one of them is perfectly apt for your exploration of epistemic injustice: nothing I have said here precludes the possibility of being able to prefer any one of the theoretical explanations I dismissed. In fact, with the exception of *hermeneutical injustice*, all other accounts managed to capture at least some element of the picture. I do not feel that this harms the tenability of my arguments in Chapter Four, as I hope to have demonstrated that Dotson's view allows us to both explain the epistemic harm in a way which does not render the research team wholly culpable for epistemic injustice, and to do so at a systemic level. This means we need not scrutinise thousands of individual communicative interactions, but can, in some ways, expect that epistemic oppression *qua* epistemic exclusion will be able to capture many ways in which experts by experience are rendered unable to contribute to knowledge production.

This, I ended Chapter Four by highlighting, is a potential problem: Dotson's view too readily explains every single case of an expert by experience not having their voice heard. The concepts of epistemic power, credibility, and the resilience of our epistemological systems, as a triad of factors undermining the contributions of marginalised knowers are perfectly applicable to any such case. This is a problem. It also demonstrates exactly why epistemic oppression is the right view to use, in my mind. As Part Three will discuss, there are no means by which we can resolve such debates, and so the views of the dominant group, who hold the epistemic power in the research setting are able to remain those underpinning our social imaginaries. Assimilating the polarity of the views I'll go on to discuss within one system would surely cause epistemological chaos, and may well serve to lay bare those limits that Dotson discussed. The issue of course does remain with respect to whether all such cases are instances of epistemic injustice (understood as epistemic oppression). However, I do not think this is a problem just for my preferred way of making sense of the epistemic injustice in these cases at all, but an issue which could challenge any of the competing accounts I set out in Chapter Three. This, I think, is because the puzzlement that remains is not particularly one epistemic in nature at all. Rather, it is a question of competing values, underlying beliefs, and what we should or should not make room for, or perhaps *can* make room for, within our present epistemological system. Any answer to questions of this sort will be fraught with difficulty. In Part Three, I'm going to argue that in mental ill health, the difficulties are multiplied ten-fold. To be able to answer the question of *when* there is an epistemic injustice, we need to appeal to an arbiter of what can, or cannot be contributed to the epistemological system. Both sides of subsequent debates would vehemently disagree with the other with respect to what the parameters of such contribution should be. As such, laying bare, and then resolving these tensions will require a level of abstraction in terms of reasoning, and thus likely is that very impossible project to which Dotson (2016) and Bartunek and Moch (1986) refer.

Part Three: ***The Centre Could Not Hold – Disagreement and Disarray in Psychiatry***

Chapter Five: **Mediating conflict – norms, values and irresolvable tensions**

1 – Introduction

Epistemic oppression is well placed to be able to explain many instances of experts by experience testimony distortion, subversion, dismissal or interpretation. Its broad applicability, though, could be seen to present a problem. We simply cannot take seriously, you may think, the claim that *any* failure of experts by experience to have their views change the course of the research, or be heeded precisely as given. Some instances where research directions are not changed based upon what experts by experience say might even be considered ethical choices, or the 'right' thing to have done. There must then, you might think, be a way of determining when credibility deficits, epistemic privilege and epistemological resilience have worked in a way that demarcates the unjust dismissals, from the ethical, or 'sensible' ones. And yet, I have argued that there often is no such way of determining what we would be wrong to dismiss, and perhaps also what we would be wrong to believe. Resolving this puzzle, I do not think is a matter which is wholly epistemic. I do not expect that my claim as such will be easy to parse for most readers, as the debates that this chapter will touch upon, as a way of drawing out the tensions inherent in making a judgement like the sort I have claimed we would need to be able to act as arbiter of epistemic injustice, are ones which most readers will likely fall strongly on one side or other. Agnosticism, or ambivalence, with respect to the tensions surrounding psychiatric legitimacy, paternalism, and culture is rare. The puzzle is then all at once normative, sociopolitical, medical, and, epistemic to a degree.

In this Chapter, I do not profess to settle any of the tensions I will set out. Rather, I hope that in establishing such tensions, and discussing the ways in which the competing or opposing arguments one way or the other, I support the claim that there is no easy answer to the question that remains: *when* is the exclusion of expert by experience testimony an epistemic injustice? However, this, I'll also say, is what makes Dotson's view so apt at capturing the epistemic injustice in such cases insofar as it shows that we could not accommodate both views in one coherent epistemology. The tensions I discuss relate to topics such as psychiatric diagnosis, social norms, treatment (including whether we should recognise a right to refuse such treatment), insight, and recovery. All, I argue, are linked, and in s.2 I set out the key factor in this debate – the lack of objective verification of mental ill health as a medical condition. As I discuss in s2.1.-2.3. this allows those who are fundamentally opposed to psychiatric intervention, from schools of thought including anti-psychiatry, critical psychiatry, and Mad Studies, as well as the broader range of people who may have experienced mental ill health care, to argue against those views commonly held by academics, clinicians, and perhaps even much of society.[128]

In s3. I then discuss the potential ways forward. I argue that coproduction, in light of the tensions I have set out, may not always be the right research approach to take, gesturing towards the need to consider who our experts by experience are, and what views they hold. This, I caution, is not without challenge. However, given that there is reason to suppose that our epistemological system may never be able to hold views separated by such polarity at once, I argue that perhaps in some instances, we would do better to abandon coproduction in favour of a values-based medicine or shared-decision making approach to research.

---

[128] For a discussion of the differences between Mad Studies, anti-psychiatry and critical-psychiatry, see especially: Beresford and Russo (2016), Reaume (2022) and Sweeney (2016).

Whilst I cannot claim to give a thorough overview of either here, I gesture towards the ways in which such research methods may allow us to work with experts by experience in ways that coproduction cannot.

This, I conclude by saying, does not answer the question this Chapter is concerned with – the matter of *when* epistemic oppression takes place. I note that given the purposes of this thesis, this need not matter all that much, insofar as the task has been to understand the epistemic injustice at play in a systematic way. And, the justification for epistemic oppression is actually strengthened by the existence of tensions like these. The debates I will touch upon could be seen as requiring means of rebuking or mediating cases where experts by experience think they have experienced an epistemic oppression, but where academics and clinicians are steadfast that they could not have taken the views seriously, to judge whether we should have believed the expert by experience or not. Not only do I argue we do not presently have such capacity, but we may have ethical concerns about doing so in some cases. I cannot allay such concerns here. However, this Chapter will set out the very real ways in which individuals within a research team, may disagree. Then, we might see precisely why Dotson's work is so particularly suited to the task of explaining the harms in coproduction.

2 – Scene-setting: tensions and disagreements

Mental ill health is not a new phenomenon, nor are recent attempts to define what demarcates mental illness from mere personality quirk, or deviance. And, though thinking has evolved, and 'disorders' that were once considered psychiatric in origin, such as drapetomania or homosexuality, are no longer considered pathologies, we have yet to locate, either in science or in society, a means of clinically determining what is, or is not, a hallmark of neurosis which requires treatment, and what are simply differences in ways of seeing and experiencing the world. What has endured, though, is a vilification or caricaturing of the 'mad' as dangerous, more prone to violence or violent outbursts, and a sense of atypicality in a societally unacceptable sense (Angermeyer and Dietrich, 2006). Even psychiatric professionals, those who one would hope and assume are less likely to stigmatise and typify those suffering with mental ill health, have been shown to prefer social distance between themselves and those with mental ill health, particularly those with diagnoses which are considered especially, or particularly, volatile or manipulative (Chartonas, 2017; Guidry-Grimes, 2019; Kenny, et. al, 2018; Gurung, et. al, 2022; Krendl and Freeman, 2019, Frances, 2014). Such stigmatic attitudes towards those with experience of mental ill health could, if one so desired, likely be used to explain epistemic oppression in its entirety.[129] Also in Dotson's work exists the concept of second-order epistemic oppression, which is a type of epistemic exclusion of individuals which has its roots in social and political factors, and thus is not properly epistemic. Rather, Dotson claims, second-order epistemic oppression is an epistemic manifestation of societal marginalisation. I've argued throughout this thesis though that some instances of expert by experience dismissal not only are epistemic injustices, but are best understood as an epistemic oppression. My argument, based upon stigma, epistemic power, and the resilience of our epistemological systems, is not reducible to sociopolitical arrangements, and thus on Dotson's view is an argument for third-order epistemic oppression. Even with that in mind, in many cases, the role of stigma may tell us much of the story.

---

[129] This would be testimonial injustice, as such stigma would give rise to stereotypes used to undermine the credibility of anyone with a mental ill health condition.

As I've indicated though, I think it likely that there will be instances whereby experts by experience are dismissed in the ways outlined in previous chapters, but where perhaps their views are such that we think it appropriate *not* to change research course based on them. I've argued that it simply is not possible to arbitrarily draw a line which separates those instances that should be considered epistemic injustices from those which perhaps should not. Here, I would like to begin setting out why this is the case. In doing so, I will draw out some of the tensions we would need to accommodate, or to resolve, to answer the question of *when* there is an epistemic injustice, in the cases I have considered.

I'll begin by looking at discussions about mental ill health more broadly, including those which trace its histories, as there are illuminating discussions which, I'll argue, cast light upon the ways in which our folk-understanding of mental ill health appears to categorise it as irrationality, or deviance, which transgresses some norm or other. Given discussions in the preceding chapter, about preconceived notions of what it means to be mentally ill which are almost ubiquitously negative in their appraisal of the capacities of those with a mental health concern, it is hard to imagine that our social imaginaries might not track such assumptions. I'll set out that discussions or presumptions about the rationality, or lack thereof, of those with mental ill health, may at first glance appear primed to explain why experts by experience cannot gain the traction they would require to prompt a revision of the epistemological system. Given that rationality is a pre-requisite for scientific knowledge, as discussed in Chapters 2 and 4, the transgression of this social norm could be appealed to explain why we cannot make room for knowledge provided by those with mental ill health. However, this norm, and in fact, the medicalisation of mental ill health at all, is bound up in a biomedical understanding of mental ill health, which has been extensively criticised by notable anti-psychiatrists. The rise of Mad Studies (more on which I'll discuss in what follows), presents fundamental opposition to such conceptions of mental ill health as disordered, or even in relation to a biomedical understanding (Radden and Sadler, 2010). The lack of objective diagnostic tests for most mental ill health conditions mean we cannot, in matters of dispute, appeal to laboratory results, as we might in physical medicine. On the question of whether views opposing psychiatry as a branch of medicine can and should be incorporated into our social imaginary, then, we have little more than our pre-theoretic commitments to appeal to.[130]

Further, when it comes to treatment, and what is or is not warranted, some experts by experience vehemently deny that we should treat mental ill health, principally because they deny that Madness requires such treatment. These views, overwhelmingly negative with respect to interventions often argue that distress or discomfort is not bound up inextricably with hearing voices, being ‘manic’, or with many other symptoms, but is rooted in the societal lack of acceptance of psychological difference. The views we might liken to the arguments for a social model, or mere-difference account of disability, which deny the ubiquitously negative framing of physical impairment, thus arguing against eliminativist projects which try to cure or prevent it. These views in relation to mental ill health are, often “incompatible with the fundamentals of their profession” for academics and clinicians (Rashed, 2019: 26). When it comes to mental ill health it can seem challenging that we might consider psychological distress, hallucinations, or even manic episodes, as merely different ways of being, if one is not already motivated by such an understanding. Yet this is what some would argue for. The question of what symptoms should qualify as indications of

---

[130] Such pre-theoretic commitments may include either an acceptance, or a rejection, of psychiatry as a legitimate branch of medicine which treats clinically significant disorders.

illness, and what we should do to alleviate those symptoms, is then another area of tension in which there is no clear solution.

Lastly, there is disagreement which emerges with respect to ‘insight’ and the overarching goals of mental ill health related care. Literature indicates that patients are only deemed to have insight into their condition, insofar as they agree with their clinicians, and even expert by experience training programs (as we have seen) ‘train’ individuals with lived experience to present their knowledge in the right ways. Related to this, is a discussion regarding what the goals or indicators of successful treatment would be: in other words, what does recovery look like? Given the denial of some experts by experience that there are mental illnesses, and criticisms that ‘recovery’ just is equal to behaving in ways coherent with social norms, what we should aim for, in terms of the outcomes of treatment are too contested.

I will discuss each of these tensions in more detail in the following sections. As a word of warning, however, I do not purport to resolve, or even attempt to resolve them here. Rather, I hope that in setting out the issues in play, my assertion that we simply cannot draw a line which neatly categorises those views we ought to heed, is strengthened. We might also understand to a greater degree why assimilating these tensions within the epistemological system as instituted in coproduction is simply not practicable.

2.1 – Irrationality, pathologisation, and norms of behaviour

Mental ill health is, almost universally, considered as a departure from rational thought or action, or as a display of enduring un-reasonability (Edwards, 1981; Scull, 1981). Our expectations of our interactions with one another, our social habits and preferences, and our systems of language, are often governed by what philosophers often call implicit norms. These norms, as sets of unspoken roles, are invisible oftentimes until they are transgressed, functioning as an ‘invisible’ guiding hand (Anomaly and Brennan, 2014).[131] Similarly, social norms determine and dictate how most able-bodied and sound-minded adults conduct their lives in an economic, social, educational, and even familial sense. There are clear, even if unspoken, norms which influence how we dress, whether we work, and how we live our lives. Although interpreting these norms is a matter of personal preference, living in a social society means many of us conform to them without even needing to be cognisant of their existence. Such norms also set, to a greater or lesser degree, along with the laws of our nation, standards for behaviour. We cannot physically lash out at another (though of course some do) if feeling disgruntled. Less extreme, though just as entrenched in society, might be our conduct in ordinary situations: queues, behaviour on public transport, norms of the workplace, and so on, all affect how we behave. Not taking part in activities which transgress, or violate, these expectations is but one of a series of hallmarks of rationality. Mental ill health, by contrast, Edwards explains:

> “means only those undesirable mental/behavioural deviations which involve primarily an extreme and prolonged ability to know and deal in a rational and autonomous way with oneself and one’s social and physical environment. In other words, madness is extreme and prolonged practical irrationality and irresponsibility.”
>
> (Edwards, 1981: 312).

Though we might hope that thinking has progressed since the time of Edwards’ writing, four decades on, mental ill health is still viewed as an unpredictable, and often uncontrollable weakness, which disturbs ones’ cognitive faculties, such as to make proper attention, thought, reasoning, and beliefs a challenge, if possible at all (Cardella, 2020; Harvey, et. al, 2004). Without appearing to argue for a behaviourist understanding of mental health, many of us, seeing someone appearing erratically, perhaps shouting out loud to

---

[131] For more on social norms, see also: Bicchieri, et. al (2023), van Kleef (2024), Evers (2017).

themselves whilst walking down the pavement, might wonder – in the absence of other indicating factors – whether this person is experiencing a period of mental ill health. Similarly, it is enduringly common for us to use phrases associated with mental ill health to denigrate, or to pass judgement on others' behaviours. Rarely do we refer to something as 'insane', 'mad' or 'crazy' to indicate our positive appraisal of that thing. Instead, those words tend to indicate some event, or behaviour which we view as being unexpected, unexplainable, or, have judged as irrational (Rose et al, 2007; Kousoulis, 2019). If these views seem dubitable, or if it seems I may be exaggerating the tendency to see mental ill health as fundamental irrationality, let me say more.

Valentina Cardella, argues that at least insofar as our folk-intuition is concerned, mental ill health is synonymous with the concept of rationality. She says:

> "After all, mad people are mad because they are irrational, and madness is the realm of nonsense, so irrationality is supposed to be a crucial part of the definition of madness."
>
> (Cardella, 2020: 17).

This, I find particularly interesting, as in the definitions of 'mental disorder' in diagnostic manuals, there is no mention of such irrationality as a central feature. And yet, it endures. Jennifer Radden similarly argues that culturally:

> "the beliefs, metaphors, assumptions, and presuppositions affecting patterns of representation, communication, and interpretation about this kind of disorder are entwined with categories and concepts fundamental to our cultural norms and values: rationality, mind and character, self-control, competence, responsibility and personhood."
>
> (Radden, 2012: 3).

Mental ill health, then, is seemingly inextricably bound up with this question around one's rationality. And, as Scrutton's (2017) work illustrated in relation to credibility, this needn't only be rationality in a sense applied to beliefs about the symptoms one experiences, but may well affect the degree of rationality you are presumed to have simpliciter.

Elly Vintiadis (2016) discusses the difference between epistemic and instrumental rationality, arguing that the former relates to the evidentiary standards for our having justified belief in some thing or other, and being willing to revise that belief in light of more compelling evidence to the contrary. Instrumental rationality, she discusses, relates more to one's acting in accordance with the pursuit of one's goals (Vintiadis, 2016). Mental ill health, she notes, is presumed to be irrationality of *both* kinds and judgements about irrationality have a bearing on who, and what we treat in accordance with our diagnostic manuals (Vintiadis, 2016; Stammers and Pulvermacher, 2020).

Now, irrationality alone helps us immediately to see *why* some experts by experience might be unable to shape or shift our epistemological systems, insofar as, as I've discussed extensively, we should only heed those views, if we are to be considered epistemically prudent, or continent (recall discussions in Chapter 1), where we are confident that our interlocutor could reasonably be expected to 'know'. I also set out in Chapter 4 the expectation that science, and by extension scientific knowledge, is rational. Setting aside the question of how we might assess whether a candidate expert by experience is rational, we might wonder whether this is just to say that we should only invite those experts by experience who we presume have reached a reasonable standard of 'recovery', and thus who are not irrational, to take part in research.[132] This, as I'll explain later, would not work, as there are similar disagreements about recovery itself.

The issue with irrationality, insofar as it is couched into the way we think of mental ill health, despite not being explicitly stated in our diagnostic manuals, is that it appears to be a signifier for those behaviours which, like Vintiadis indicates, either defeat our epistemic, or

---

[132] This would too make an assessment of rationality impossible, insofar as it would equivocate rationality with sanity, or agreement that one has a clinical problem, which would be to presuppose that mental ill health entailed by definition that one should not be considered a knower whom we ought to listen to.

our instrumental aims. In other words, it is behaviour which contravenes some norm or other. And this, has led notable figures to question the legitimacy of psychiatry as pathologising behaviours which violate such social norms. Irrationality is a judgement that we make, often about things we do not understand or think sensible, much like the way we use ‘insane’, or ‘mad’ to indicate our judgement that a choice our friend made was not sensible, or was ill considered. Without wishing to plunge into the depths of anti-psychiatry literature, for that could itself comprise an entire thesis, this point is precisely that made by Thomas Szasz, and to an extent, Michel Foucault.[133] Szasz’s infamous *The Myth of Mental Illness* (1974) argued that mental ill health, where it could not be proven to be a disorder of one’s brain, should be considered “problems in living”, and that medicine itself should not intervene with such problems (Szasz, 1974). He is read as also arguing for the view that problems in living just are those norm contraventions I mentioned. Why is this a challenge to psychiatry, and not just a view we might dismiss as being slightly left-of-field? Well, primarily because normative understandings of behaviour or psychological processes *are* indeed baked into the very understanding that some have attempted to make of mental ill health ‘disorders’. Jerome Wakefield (1992) argues for a *harmful-dysfunction* account of mental ill health, whereby in order to determine that one has a mental ill health condition, we must satisfy ourselves that there is a psychological process or function which has gone awry, and that function must be categorised as ‘harmful’ in its effect (Wakefield, 1992b). Now, Wakefield’s work was not to make normative understanding of mental ill health, rather to give us a means – because of the lack of objective testing I have indicated in psychiatric

---

[133] Given that Foucaldian thought falls outside of the feminist tradition, and is extensively discussed as a discipline or philosophical focus of its own, I do not attempt to summarise Foucault’s position here. He did, of course, view psychiatry it as a system of state control, which pathologised what it considered deviant behaviour (Foucault, 1988, 1994).

medicine – of demarcating between expectable but not pathological distress, and 'disorder' (Wakefield, 1992a, 1992b). However, the normativity enshrined within this view is indubitable. Similarly, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) 5th Edition (2013) could be argued to leave room for normative judgement, as whilst it stated social deviance or conflict was not grounds for diagnosis in itself, this was immediately caveated with: "unless the deviance or conflict results from a dysfunction in the individual" (APA, 2013: 20).[134]

I raise these points not to lend sympathy to the view that there is no role for psychiatry, or even that we ought to question its reach or legitimacy, but to illustrate that our understandings of mental ill health do not, in most all cases, preclude social deviance, or norm transgression from being part of the reason we might suspect someone to be ill. This, Mad Studies scholars have argued, *is* a reason to question the fundamental legitimacy of psychiatry as medicine. Campbell (2022) for instance, says of psychiatry:

> "I see [it].. as a mechanism of social control. Individuals are controlled by being compulsorily detained…. [It] acts conservatively, reinforcing social prejudice and fitting its recipients into the status quo, rather than trying to change their social environment. While ostensibly looking only to help the distressed, psychiatry is in fact moulding them for roles as the disempowered"
>
> (Campbell, 2022: 59).

Similarly, Brenda Del Rocio Valdivia Quiroz (2022) reflecting on her own experiences in the mental health system says:

---

[134] The full DSM 5 definition of mental disorder was as follows: "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above" (American Psychiatric Association, APA 2013: 20).

> “For as long as I can remember, I have been classified as someone who deviates from “the established norm” in various ways. Sometimes, being different and being able to raise my voice have led me to stand out, and receive social recognition for it. On other occasions, I was pressured to repress that and adjust to “being normal”. It turns out that deviating from the norm is fine only as long as it does not go against the system”
>
> (Del Rocio Valdivia Quiroz, 2022: 41).

Mad Studies scholars, then, understand their pathologisation in ways consistent with Szasz’s (1974) view, as ways of being different, which are not accepted by psychiatry as permissible. Psychiatry’s approach is then to treat, or attempt to remediate the distress, behaviours, and symptoms associated with such illness. Oftentimes, though, this is viewed negatively by those who question the validity of diagnostic groups, or medicalisation of difference.

These debates are not only incredibly interesting, but help us to make sense of why some experts by experience, who hold the latter sort of views, might clash with – and ultimately find their views rebuked or dismissed by – academics or clinicians whose training has taught them that mental ill health *is* a medical condition, and further, is one we ought to try to treat in the interest of patient safety. The inability of an epistemological system to hold both of these conceptual understandings, of mental disorder vs. socially impermissible, of medical vs. control based, is then understandable. Neither side is likely to be persuaded by the other: the discussions I began this section with, though, might help us to see how and when the assertions of those who deny psychiatric legitimacy are dismissed as being irrational. The lack of any sort of means of appealing to something more objective than one’s own view, educational history, and developed understanding, is not possible. But, to each side in this debate, the other could ostensibly be understood as unintelligible.

2.2- Treating symptoms: First Do No Harm

Similarly opposing views exist with respect to both the need for, and choice of, treatment. As you might expect, those who have been trained in the psychiatric tradition do not question whether to treat, but rather which treatment, in which circumstances is advised. There is a scarcity of literature authored by academics which ask about the legitimacy of treatment at all. Rather, the goals of psychiatric medicine can be understood as attempts to alleviate suffering, and to safeguard the interests of patients. This is where questions of paternalism are often raised, as we saw in relation to Tyreman's discussion of how much we should regulate expertise (Tyreman, 2005). And in relation to psychiatry, and mental ill health, paternalism can extend beyond simply believing one knows best what is right for the patient, to circumstances in which patients can be forced to have treatment, or to otherwise be detained to protect their safety. The opposite of paternalist views, Jennifer Radden (2003) discusses, are those which prefer a liberalist approach to mental ill health, and which maintain patients have a right to choice (Radden, 2003). Such views, however, if one is of the view that psychiatry itself is not reality-tracking, but is pathologising difference, like those discussed in s3., can lead to the consequence that some individuals, that most psychiatrists would prefer to medicate, or engage in therapeutic work, can outright refuse to engage with services. On such a liberalist view, Radden says:

> "For example, those adopting a position which denied the reality of mental disorder would attribute full autonomy and responsibility to the mentally ill. For such a position, the right to refuse medication prescribed merely to ensure the patient's own safety, wellbeing, or best interests must be an absolute right."
>
> (Radden, 2003: 1).

However, as she notes, there is rarely – among those who don't adopt a position like that she describes – disagreement when it comes to the more extreme cases.[135] Such extreme cases are likely, I suspect, to include those collections of symptoms that are understood as Severe Mental Illness (SMI). SMIs typically include mental ill health conditions which are believed to be enduring, that is without treatment they likely will not abate or resolve, to be inextricably linked with harm to the individual, perhaps because of a lack of decisional capacity or increased likelihood of suicide, and to be correlated with significant social difficulties, which may look like an inability to maintain employment or secure housing. Typically, amongst the vast number of mental ill health conditions that the DSM describes, the 'cluster' of those which are considered SMIs include schizophrenic type conditions, bipolar conditions, and occasionally conditions associated with psychosis. The symptoms of such can include hearing voices which impel one to do harm to oneself or others, a detached or distorted sense of reality, engagement in high-risk behaviours or activities, and disturbances in one's thoughts or beliefs.[136] Central to decisions to 'force' treatment, however, tend to be presumptions or judgements that the individual afflicted is no longer able to make rational decisions, competently, to safeguard their own wellbeing. And various justifications have been given for this, including those which appeal to what the individual would have wanted had she not been experiencing the psychiatric distress she now experiences (Radden, 1992, 1994, 1996, 2003; Kultgen, 1995). This, though, is an argument fraught with difficulty, as not only does what we want for ourselves change over time, it has been called the disability-paradox, insofar as when used in relation to health or disability to

---

[135] There will of course be disagreement from those who do not think that mental ill health conditions exist.

[136] Whilst this sentence is not impartial, insofar as it indicates that I believe these are symptoms of a mental ill health condition, an entirely impartial overview of the debate does not feel possible. I will come on to discuss the ways in which Mad Studies' scholars describe or discuss these in non-pathologising ways.

express, by that disabled individual, that they are happy with their lot, it is presumed to be an adaptive preference (Barnes, 2009; Stramondo, 2021). Adaptive preferences are understood as modifications to what we want, based on what is possible for us, or the position at which we stand, at the time of judgement making. Barnes classically uses the example of a fox in an orchard who wants to eat grapes, but cannot reach. The fox may come across a bush full of berries, and decide he prefers berries anyway, as grapes are too sour for foxes (Barnes, 2009). The fox, in Barnes' example, modifies what he thinks he wants, or would have wanted, based on what is available to him. This, is what some tend to presume happens when one values disability, or denies wanting to remove the symptoms of mental ill health that one is facing. But, in anorexia nervosa, for instance, there have been some studies which suggest that refusal of treatment goes further than adaptive preference, but could actually be what the individual wants, based on rewiring of their neural pathways (Walsh, 2016). It could thus actually be the patient's real-time preference to not undergo treatment, and capacity judgements aside, paternalism would be the only route available to us, should we wish to determine a need for intervention irrespective of that patient wish.

Discussions about whether patients should have the right to refuse treatment aside, there are questions remaining about *which* treatment is the most apt in any given scenario. Typically, this could range from hospitalisation to medication, to talking therapies, to more invasive therapies such as electro-convulsive therapy. The latter, though used less in recent times, was once a widely deployed treatment for a whole host of mental ill health conditions and was never popular amongst patients (Rogers and Pilgrim, 1993). The National Institute for Health and Clinical Excellence (NICE) in the UK has responsibility for publishing recommended treatment guidelines for any particular condition, and physicians and clinicians are then tasked with working with patients to make preference-sensitive choices

(Thompson and McCabe, 2018). However, a *laissez-faire* approach, particularly to SMI, is rare, ordinarily, if you believe that such conditions are a serious as they are purported to be, treatment is indicated, the discussion or deliberation is then which of the available options is best.

There is not consensus though, among those who challenge psychiatry, that treatment is warranted in many, if not all, circumstances. Irit Shimrat (2022) in discussing the role of survivor knowledge is explicit that psychiatry and psychiatric treatment is negative, and has the effects of provoking incredibly hostile sentiments. He says that live experience generates narratives about the:

> "incarceration, torture, poisoning, electroshock, humiliation, etc., at the hands of psychiatry; the resultant terror, rage and angst; and how all of this can be used against us by "helping professionals" and hostile researchers"
>
> (Shimrat, 2022: 53).

And such views tend to be, though are not always, motivated by a belief that the symptoms of mental ill health can be likened to 'special gifts'. DuBrul says of this:

> "What do the ravings of a madman look like? Are they always incoherent nonsense with little relationship to reality? Or is there a brilliance sometimes, an ability to see phenomena as part of larger systems, to recombine the elements of daily existence through linguistic tricks and the unequivocal magic of metaphor into something that allows us to see a continuity between every little piece of dirt and every human bone that is always present..?"
>
> (DuBrul, 2014: 267).

As I noted in Chapter 4, DuBrul, and others, who diagnostically are considered to have SMIs, held a view considered fairly extreme by some, that SMIs were no more than 'dangerous gifts' to be cultivated. The Icarus Project, as the name suggests, likened SMIs to the gift of flight, with the individual with a mental ill health condition responsible for cultivating that gift, so as not to fly too closely to the sun. Treatment of any sort, I would posture, would be refused by those with such a view. Menzies, et al. (2013), argue similarly, describing Mad Studies as an abolitionist project aiming to denounce the control that psychiatry has over those it considers ill, refusing that treatments are legitimate, and denying that they should ever be forced (Menzies, et al, 2013: 17).

This is, of course, not to imply that no individual would ever choose treatment, for they may well do. My point here is to simply draw out that there is little in the way of agreement about the right treatment, and the right circumstances in which to take decisions about that treatment. The more extreme psychiatry-critical views are suspicious with respect to the utility of treating symptoms, and even go so far as to view them as violent and coercive. Even liberal views held by academics and clinicians, as Radden noted, would struggle to gauge some of the potential consequences of a completely patient-led approach. This too, would only be resolved by a resolution of the initial tension I set out, with respect to rationality, and indisputable evidence of psychiatric disorder as a medical issue.

Why might this matter in coproduction? Simply, because if a project is focused on which treatment is best for a particular condition, and these two opposing views or grey areas are in dispute, aside from falling back to our respective values (those which see psychiatric medicine as legitimate and doing good, versus those who see it as a coercive tool, diminishing or dulling one’s sense of self, and thus doing harm) there is little we can do to mediate or traverse those disagreements. Again, whilst matters of treatment may be more able to be negotiated that the question of psychiatric legitimacy simpliciter, if fundamental beliefs are steadfastly held to, they likely both cannot be contained within the same epistemological system. Further, in this case, because there is a likelihood that the treatment-oppositional views are themselves dysfunctional or perhaps even indications of pathology, we might be able to see why they are often understood as hallmarks of mental ill health. The notion that mania is a special creative gift, or that hearing voices is an innocuous experience, are for many, myself included, challenging to parse.

2.3 – Goals: insight and recovery

The final 'tension' I wish to outline, which is not distinct from, but is closely related to the two previously outlined tensions in s2.1. and s2.2. relates to the differing views that experts by experience, and clinicians and academics might have with respect to the goals of psychiatric intervention. This relates to both the concept of *patient insight* and to *recovery*. Both, as I'll explain in what follows, are contested.

Insight, has been discussed in psychiatry since Aubrey Lewis (1934) first used the term in relation to mental ill health. As a kind of self-awareness, or perhaps a reflection on one's ill health or period of distress, it requires that patients acknowledge or express a "correct attitude to a morbid change in oneself" (Lewis, 1934: 333). Though conceptually it has not been defined in terms accepted by all, which has prompted much in the way of discussion, including the development of measurement frameworks, the core sentiment of patient insight as being this sort of self-awareness has persisted (Marková and Berrios, 1992). Anthony David conceptualises 'insight' as being comprised of three dimensions: "the recognition that one has a mental illness, compliance with treatment, and the ability to relabel unusual events as pathological" (David, 1990: 798). A lack of insight, then, is often considered to be a hallmark of mental ill health, insofar as a lack of insight or recognition that one is experiencing symptoms which are abnormal or unusual, can indicate to a clinician that something is amiss. You might think insight just is integral to expertise by experience, as it pertains to knowledge of the experience of ill health. This, however, would be to confuse the multiplicity of terms with which we are working. There is nothing bound up in the concept of expertise by experience, though we might think there ought to be, regarding patient insight. This could be, as Laura Guidry-Grimes notes, because the concept seems to be subject to:

> "a circularity problem when 'awareness of illness' is construed as willing- ness to accept treatment, so only those who are adherent could have insight"
>
> (Guidry-Grimes, 2019: 179).

In the literature, only those patients who accept that their symptoms are indeed a mental ill health condition, and who agree with, and adhere to, recommended treatment, can be considered to have insight (Guidry-Grimes, 2019). This leaves open questions, which Guidry-Grimes sets out, as it is remains unclear from discussions to what extent patients might ever be considered to have insight in cases where they either disagree that they have a mental ill health problem, or where they disagree with their clinician about how to handle that problem. If those two examples sound familiar, that is because they are very closely linked to the first two tensions I have set out, in relation to psychiatric legitimacy, and treatment choice.

David (1990) argues further that "at best" we might say that a patient who denies the existence of a mental ill health problem, but is nonetheless treatment compliant, has partial insight. But, we cannot judge them as having insight – and so might presume that they lack some rational capacity for appraisal of their own experiences – unless they accept their diagnosis. This is too echoed by Liliana Dell'Osso and colleagues (2002), and by Amador et al. (1991) who argue that insight can only be possessed by patient's whose view is congruent with that of their psychiatrist. Zsuzsanna Chappell and Sofia Jeppson (2023) have argued against these kinds of views, claiming that we ought to listen, or at least attempt to listen properly to "people's own assessment of the (dys)function of any problematic behaviour, cognition or emotion" (Chappell and Jeppsson, 2023: 301). Listening to such assessments, though, I suspect does little to persuade those who think insight is agreement with clinical assessment, where that 'own assessment' to which Chappell and Jeppsson refer, is one which denies there is a clinical problem at all.

We need not even really refer or revert back to those views of experts by experience I have outlined in s2.1. and 2.2. to see why this might present a challenge for such experts by experience in coproduction. If insight just is acceptance of the medical view, and one does not accept the medical view, then one's judgements are indeed likely to be called into question, when voicing as such. It could be that the coproduced research project is on the topic of insight, and that experts by experience are trying to assert that psychiatry does not really track illness, but is a tool for state control; it is not hard to imagine how their contributions might land in such cases.

Similarly contested, might be the notion of recovery itself. Chappell and Jeppsson (2023) have argued that ordinarily, 'recovery' for psychiatric professionals just means that the goal is "normalcy" (Chappell and Jeppsson, 2023). And this seems hard to argue with: oftentimes the goal of treatment, as I outlined in the preceding section, is to remove or reduce symptoms and the distress caused by those symptoms. If normalcy is understood in a behavioural, or a social sense, the lack of symptoms is thus likely to coincide with a return, or perhaps commencement depending on illness duration, of those social functions we normatively consider 'good' for a person. This might include returning to work, more stable living environment, maintaining of one's personal hygiene, and so on (Guidry-Grimes, 2019; Liberman and Kopelowicz, 2005). These views are, in many ways, telling. First, if the goal of treatment is a 'return to normalcy', then inherent in that statement is an understanding that mental ill health is *ab*normal, or *dys*functional. This, of course, tracks the sorts of concepts which seem inextricably bound up with the concept of mental ill health, but, one might imagine this creates tension with those who think that such appraisal is part of the system of control which psychiatry attempts to have continued. As an alternative to the clinically measured ‘recovery’ then, the concept of ‘personal recovery’ was introduced by some, as a concept focused more on hopefulness, and progress, as opposed to having ticked some milestone medical box, or having satisfied a norm in one way or other. This too, though has been criticised, and rejected by some because it has become supported by the mental health care system. And those directly opposed to the mental health care system, typically do not wish to see their understandings take on medicalised meaning or emphasis (Chappell and Jeppsson, 2023: 301).

Again, it is not difficult to see here how a tension arises between those who accept and perhaps want, a return to ‘normal’, and those who see the very notion of meeting normative expectation with respect to one’s emotional, behavioural, and social life as being a way of being controlled by a system in which they do not believe. Chappell and Jeppsson’s own paper, whilst giving an excellent overview of what they discuss as a normalcy bias, argue for a concept of recovery in relation to deliberate self-harm which is not wholly linked to the cessation of such self-injury, but instead looks at the roles such a behaviour plays in one’s life (Chappell and Jeppsson, 2023). I suspect this sort of position would be a difficult one to sit with, clinically speaking, though may not be altogether rendered impermissible, but a view of a more extreme sort, such as recovery which allows for enduring symptoms of psychosis, likely will not be. And yet, some maintain that such symptoms are merely differences in perceptual experience. Balancing this latter sort of position in coproduction is likely, as with other discussions here, impossible within the bounds of our present epistemological system. We cannot both defend psychiatric legitimacy and the need for mental health care, treatment, and recovery, and accept that those things called mental ill health conditions are not illnesses at all. It seems to me that there is no amount of epistemic work which could make congruent these opposing camps: as the title of this thesis Part suggests, attempts to hold both views true would likely throw our entire epistemologies relating to mental ill health into disarray.

3 – Where do we go from here?

These tensions, as I have set them out, between those who do, and others who do not, stand firm in their commitment to the legitimacy of psychiatry or the approach of psychiatric medicine, then, helpfully demonstrate why room cannot always been made within our epistemological systems for views from both parties. Often, whether because psychiatric medicine is the more powerful institution, or because histories of understanding mental ill health in a biomedical sense precede the emergence of those opposed to psychiatry, it will likely be the case that, for the reasons discussed in Chapter 4, it is the views of those experts by experience which argue against psychiatry in some way which are not allowed to shape our understandings. The normative question of whether they should, I think, can only be answered fully by resolving these tensions.

The work to resolve such tensions, I cannot profess to even have begun to do here. I maintain that it is possible that academics and clinicians on the research team may mean to include experts by experience, and that perhaps they might even manage to do so in some cases. But where such fundamental opposition lies at the core of what an expert by experience is attempting to convey, we must remember that the coproduced project likely originated *from* within psychiatry, or clinical care, and thus the shared hermeneutical resources will be ones which have such a biomedical, or even biopsychosocial understanding of mental ill health as a central tenet. This is because, as the academy presently is organised, research grants remain in the control of those traditionally qualified. When faced with such extreme, oppositional views, Jennifer Radden and John Sadler note, it may be all that the clinicians and academics can do is to:

> "try to understand, and to respect, these alternative perspectives, recognising the degree of controversy attaching to these ideas, and understanding the source of that controversy—the extent to which they rest not only on discoverable empirical realities but on deeply held moral and philosophical attitudes and beliefs"
>
> (Radden and Sadler, 2010: 58).

Others, though, would argue against this, claiming that anything less than centering the views of those who have lived mental ill health, is akin to silencing them. Jasna Russo (2022) for instance, is unpersuaded that these questions are matters of perspective, arguing that:

> "What we are dealing with are not differences between perspectives and schools of thought. We are dealing with the systematic epistemic erasure that has lasted for centuries. The forms of epistemic injustice differ according to the historical epochs in the ways societies and their ruling regimes (mis)understand and approach 'madness'. These traditions range from active silencing, ignorance, belittlement, re-interpreting, overwriting, appropriating up to the level of issuing glossy invitations to 'co-production' or subtle remaking of 'survivor-control' into 'consumer-leadership'."
>
> (Russo, 2022: 27).

These quotes, I include to show the gravity of the task that would lie ahead, if one were to seriously argue that coproduction was the methodology that *all* research into mental ill health should employ. I think, it is evident from discussions throughout this thesis, that it should not be. These are not matters on which psychiatry can simply 'make room' for the alternate view or position, at least not whilst committing to coproduction as a research approach; to do so would be to undermine psychiatry's entire ethos and to give up its commitments to the concepts of mental ill health as conditions which we can, and have, treat(ed).

What discussions here do demonstrate, neatly, I'm inclined to argue, is why Dotson's framework of epistemic oppression so aptly captures what happens in coproduction. This, of course, is in the more challenging cases where expert by experience contribution aims to take research in direction incompatible with what is currently clinically accepted. The epistemological system could not plausibly contain both ways of understanding diagnoses, treatment, insight, or recovery: the views outlined are polarised to such a degree that they cannot be made compatible with one another. Relatedly, if it were to be the case that we conceded an expert by experience *was* right, this would serve to undermine our entire knowledge base with respect to psychiatry in terms of what it is for, and what it is focused upon. Thus, whilst these tensions are irresolvable here, and whilst this does mean we can't determine when we are right to dismiss such polarised views versus when we should heed them, the tensions demonstrate that epistemic oppression does well at making sense of the cases in play.

What, then, should be the route forward? I'm inclined to say that based on the discussions here, and all I have said in other Chapters, what we ought to do is to consider where coproduction might be appropriate, versus when it might not be. This might, for example, including considering who our experts by experience are, for any particular project. On matters of psychiatric diagnosis, for example, we might think it advisable to ensure that ones' experts by experience are not of the view that all diagnosis is non-reality tracking. This does then run the risk of leaning towards the *active ignorance* and *closed-mindedness* that Medina cautioned against (2011, 2013). By refusing to even invite those to the table whose views are not congruent with our own, we do little to generate that *epistemic friction* that Medina claims is central to avoiding such epistemic vice. Continuation of current practice though, causes epistemic harm, even if it subsequently does medical (or mental) good.[137]

---

[137] This does open the possibility of taking a utilitarian type approach to research in mental ill health, whereby if the findings themselves are able to do more good than the harm done to those experts by experience that we do not heed along the way, we might allow it. However, I think such an approach would not only deepen

Levelling the playing field by ensuring that power truly is shared, and perhaps giving up, insofar as it is possible to do so, one's epistemic power, or stepping outside of current research hierarchies may do much in the way of ensuring experts by experience are able to contribute. So too would ensuring that credibility really is offered in accordance with the evidence one has that experts by experience have knowledge. I do not doubt that many do. I do not even go so far as to say that those who hold views like those, I have discussed in s2.1.-2.3. are not experts by experience: the purpose of my discussions here has been to show that it is perhaps not easy to argue that such experts by experience are not experiencing an epistemic injustice *qua* epistemic oppression, even though so much would need to be given up to accommodate what they know. As challenging as this statement may be to parse when one considers the kinds of views a redress would demand we take seriously, I make it all the same. Given that epistemic oppression simply requires that stigma, epistemic power, and epistemological resilience come together to render a view unintelligible, it *is* able to account for even those cases where we think we shouldn't alter research course.

Perhaps it is more that we need a means of ascertaining what really is evidence of psychopathology, and what is not. This, however, has been a project enduring for decades, and there is little reason to suppose such determinative findings will emerge in the near future. In truth, I do not have an answer here which would satisfy any reader.

If we really seek a way forward which avoids such epistemic harm, in contexts as polarised as mental ill health, then, the best approach may be to work with the aim of dissensus building, as has been discussed in recent times in relation to values-based medicine (Fulford,

---

the divide between the two camps, but would be ethically pernicious. It would also go against the very ethos of coproduction.

2004, 2008; Handa and Fulford, 2023). This would be a move away from coproduction, though given the arguments here, such a departure from present ways of working may be no bad thing. Dissensus building via values-based medicine may well be able to avoid perpetuating similar harms.

As a complement to evidence-based medicine, values-based medicine focuses on what matters *to* the patient. This makes it well placed to deal with matters of resolute disagreement. Once what matters to the patient is established, clinical teams can work together with that patient, to centre their values and allow this to shape what treatment they do, or do not proceed with. It does, in many ways still require that a patient (in a clinical encounter) be willing to work with their clinicians in this way, but it allows room for conversations about what matters, as opposed to what diagnosis, treatment, or concept of recovery, is made room for (Handa and Fulford, 2023). Values I have not discussed much until now, but I think them central to any resolution of the thorny issues I have set out. Focus on values would not I do not think, resolve the tensions as I have set them out, but perhaps would allow us to side-step such tensions, beginning research from a different place. Anna Bergqvist's (2020, 2023) work supports this sort of understanding of the ways in which discussions about values may help them to become clearer, insofar as she understands values as existing "discursively in the interactions between people" (Handa and Fulford, 2023: 239). They can thus be shared, and Bergqvist notes that:

> "'sharing… implies precisely not a consensus model of 'value agreement'… 'sharing values' here denotes rather the open-ended dialogical process of the different stakeholders coming together with the shared aim of *reaching a decision* given the contextual parameters of the local treatment situation and the wider healthcare system in question"
> (Bergqvist 2023: 178).

This has the appeal of being a process by which research could be approached where neither party would need to persuade the other of any particular way of seeing the world as the ‘right’ way. Nor, as I indicated, would a move to shared-decision making method drawing on VBM require giving up on any professional commitments for the clinicians and academics in the research team. Rather, it might allow what truly matters to be shared amongst the group, with research progressing from there. This, of course, may not be appropriate in all cases, but, as I’ve discussed coproduction here, there is little reason to suppose it is currently doing better. By sharing values, and determining how best to work together, it may be that both parties (the traditional researchers, and experts by experience) can forge a path ahead which allows for new understanding to be developed in ways which do not require giving up of either side’s value commitments. This will not, of course, work in all cases. However, I am sceptical that there is any one methodology which could, or perhaps should be universalised. In the same way a randomised controlled trial would not be used over a focus groups if one wanted to elicit views of those who had taken a particular medication, neither coproduction, nor VBM and shared-decision making, ought to be viewed as *the* research method, or approach, to choose. Instead, we might take a step back and think about our purposes. If our goal truly is to seek the views of, and to involve individuals we believe have knowledge, gained by living with mental ill health, then it is imperative that room is made for the views that they might express. We may still, of course, require that our experts by experience be ‘stable’ so as to not cause psychological harm or distress, but we ought not to invite people to take part for taking part’s sake.

4 – Concluding remarks

This chapter began with a question: when is the exclusion of experts by experience an epistemic oppression? Such a question is motivated by, and rests on the acceptance that not every dismissal, subversion, or exclusion of knowledge offered by experts by experience should be understood as an epistemic injustice in this way.

I explained in s2. that a resolution to this question could only be offered if we were able to resolve some key and central tensions that exist between experts by experience and clinicians and academics. Such tensions strike at the very core of one's fundamental assumptions. As I set out the issues in s2.1.-2.3. I outlined that there is disagreement regarding the legitimacy of psychiatric medicine, the notion of what becomes pathologised by such clinical endeavour, the question of whether and what treatment is appropriate for any cluster of symptoms, and importantly what we should do where patients do not want such treatment, and the concepts of insight and recovery. Without reasoning from one or other 'camp' in these debates, I do not see how we might resolve them. There simply is no arbiter of 'truth' in such matters; there is, however, plenty of opposition.

This, I have argued throughout is helpful, insofar as it shows the gravity of the task required, if we were to take seriously that all such views should be heeded, and that the epistemological system, instituted in research contexts be shaped and shifted in accordance with that wealth of views. It is indubitable that it casts coproduction in a negative light, where one might wonder what it could ever achieve in light of such conflicts. There are, though, instances of this done well, and perhaps a way forward would be to explore what those successful projects have in common, particularly as that relates to disagreement. In terms of epistemic oppression, 2.1.-2.3. illustrate, helpfully, I think, *why* the epistemological system cannot contain both views simultaneously. This, whilst approached with the aim of showing when exclusion may *not* be an epistemic oppression, has, I've argued, shown instead just how well suited the framework of epistemic oppression is to the task at hand in this thesis.

In s3., I gesture towards a potential criterion for including experts by experience, insofar as we could seek assurance that their opinions are not fundamentally in tension with the tenets of any particular research project. This, despite Medina's likely protestations about active ignorance and closed-mindedness, could be a way forward. However, as I outlined, so too could the adoption of shared-decision making and VBM. As a method which allows for competing values, and in fact expects such conflicts, VBM – though far more complex than I have been able to set out here – may allow a path through the polarity of attitudes and views, by focusing on *what matters to patients*. Psychiatry, and by extension psychiatric research, as a discipline focused on reducing, preventing, and treating mental ill health, after all, ought to have this concern at its core.

Lastly then, to reiterate, I do not claim to have resolved any of the tensions that this chapter set out, nor do I think there are easy resolutions to the question of 'who is right?'. As it pertains to epistemic oppression, this means that whilst I think there good reason to suppose this an efficacious means of understanding this epistemic harm, I thus leave open the question of *when* it might be appropriate to understand the exclusion of experts by experience in such a manner. We could argue that if experts by experience feel that in their capacity as knowers, they have been unable to shape knowledge production, then it matters not whether normatively we think we should have allowed their views to do just that: in such cases, perhaps epistemic oppression could and should explain every instance that this occurs. I think, we might do better than that, in the sense of the systemic explanation I have argued for throughout this thesis: it is not the case that we must settle each and every exclusion as being either warranted, or not. Rather, what I think we can say, in conclusion, is that systematically, experts by experience are likely to experience epistemic oppression, and this likelihood is because they have knowledge which our epistemological systems simply cannot contain.

Conclusion

What then remains is to summarise the arguments made within this thesis, and to highlight the key, and novel contributions to the debates considered.

I set out with a purpose: to explain the exclusion of experts-by-experience in coproduction as a kind of *epistemic injustice*. This alone would not have been an especially exciting discussion, as, as I highlighted early on there are many such accounts which view the dismissal of those with lived experience of mental ill health, in almost all contexts, as an epistemic injustice. I then, took a slightly different approach. Below, I return to each of the key questions which were fundamental to the path taken through the debates to summarise the answers, and, where I feel my approach or conclusion has diverged from what is already known.

1- Where is the harm in coproduction?

I began by asking what about coproduction has been considered harmful. The answer to this, formed the basis for discussions throughout the thesis, as I understand the harm in coproduction to be the distortion, subversion, interpretation, or outright dismissal of expert by experience views. This is pernicious, I argued, principally because such occurrences appear to rest on experts by experience having had mental ill health concerns: the very reason they have been invited to take part in coproduction. As I noted, the tendency in relation to mental ill health in its entirety, given the stigma faced by this patient group, is to understand such dismissals as instances of epistemic injustice. Here, I urged caution claiming that the tendency to immediately understand lack of uptake as epistemic injustice may serve to dilute the utility of the concept of epistemic injustice. Instead, I argued, we must ask whether patients' do indeed 'know'.

2 and 3- What is the role of knowing in assessments of epistemic (in)justice? Can patients possess expertise?

The first significant contribution to the literature that I made then, related to the role of knowledge in determining whether dismissal constitutes epistemic injustice. I argued that, following Byskov (2021) in order to conclude that some individual or other has been harmed in their capacity as a knower, we must demonstrate that there is in fact knowledge which they possess, and which we harm them by failing to take seriously. Discussing the concepts of epistemic continence, and epistemic prudence, I argued that in instances where an individual with lived experience could not be presumed to *know* and where that knowledge were not of a sufficiently developed degree to challenge, or be taken as warranting equal credence to knowledge of academics and clinicians on the research team, we should not believe them. This is a strong claim and not one that I suspect many philosophers would feel comfortable with. However, I argued that we cannot undermine someone as a knower if they do not in fact know. This alone, I claimed would not go far enough, as academics and clinicians possess expertise. The second contribution that this thesis makes to the literature then, is a discussion of the concept of expertise by experience, which is specific to mental ill health, and whilst proceeds from discussions of traditional expertise.

The upshot of this exploration Is that we can conclude that at least some individuals called experts by experience do possess expertise, and thus failure to take seriously that expertise might rightly be considered an epistemic injustice.

4 and 5 – Which theory of epistemic injustice is best placed to explain these cases? Can we give a systemic explanation for the epistemic injustice?

I then consider *which* theory of epistemic injustice we might apply to make sense of the epistemic harm in coproduction. Here, there are several things to say. Arguments in Chapter 3 demonstrated that there are similarities, and linkages, between many of the ways philosophers have talked about the harms done to knowers. All of the accounts discussed manage to capture some element or other of what appears to happen in coproduction, though I ultimately found each lacking in terms of giving a comprehensive, systemic explanation. This should not be read as my making a bold claim that the theory I find most able to capture the epistemic injustice in coproduction at a systemic level, is the only one we might apply. Rather, I think Chapter 3, and a consideration of epistemic injustice rooted in stigma, or power, or the possession of relevant concepts demonstrates that which view will be most apt will depend on our purposes. Any one of the alternatives that Chapter 3 considers may well be sufficient to explain a harm depending on the level of explanation you seek.

However as that my purpose was to provide a systemic explanation, I argued that Kristie Dotson's (2014) account of *epistemic oppression*, and the ways in which it draws on the concepts of the social imaginary, shared hermeneutical resources, and epistemological resilience, capture neatly the ways in which experts by experience may find themselves epistemically excluded in knowledge production endeavours. This, I argued in Chapter 4, can be loosely diagnosed as being based on three key facets. First, experts by experience, because of their mental ill health, are more susceptible to being given credibility deficits which affect the degree of credence their assertions are afforded. Assumptions are easily made that their mental ill health comprises their judgement. Second, experts by experience in virtue of being non-traditional experts, stand in a position of less epistemic privilege than their academic and clinical counterparts. Knowledge rooted in experience is then not of the right sort to challenge that which is generated by study and clinical practice: science, our intuition may tell us, should not be subjective. Lastly, experts by experience, because of their credibility deficits, and aspersions cast as to the scientific nature of their views, cannot generate sufficient epistemic friction to prompt revision to instituted epistemologies. By this, I mean that where their views are unable to be 'held' within our epistemic lifeways as they are presently organised, experts by experience simply cannot show the insufficiency of the system. This is not their fault. Nor, as I've argued, is it solely a matter of culpability on the part of academic and clinical team members. The knowledge that will present issue, I've argued, is such that it would throw anything we hold certain into disarray. This, Chapter 5 demonstrated, is because there are fundamental and inherent tensions relating to views about psychiatry.

A challenge that I have not been able to resolve is the question of whether Dotson's view applies too widely: as I have cast the view, there is no scope for an instance where we feel we should not have believed an expert by experience, particularly if we have shown their knowledge to be equivalent to expertise. Highlighting the tensions which cause issue here, though, did aid in getting us to the last novel claim that this thesis adds to the literature base: coproduction simply is not an efficient research methodology to employ in all mental ill health related research. Its popularity has led to coproduction becoming a panacea in the research landscape, and perhaps it ought not to be utilised quite so widely. Other alternatives, such as values-based medicine, and the concept of shared-decision making, I claimed, may do better in matters of polarity, insofar as these process-based methodologies may give us a means of progress in matters of dispute. Neither methodology, however, resolve the tensions between those who fundamentally believe in the value and legitimacy of psychiatry, and those who do not. The tensions that this final Chapter sets out though, I have argued, demonstrates exactly why Dotson's view is so well placed to explain what's at play in coproduction, the fundamental beliefs of academics and clinicians on the one hand and (some) experts by experience, on the other, are irreconcilable.

Further directions

This thesis also sets the groundwork for further exploration and argument relating to an array of topics. First, the tensions set out in Chapter 5 could be further explored through the lens of research praxis. By this I mean that an exploration of how, and where, different methodologies may be able to make sense of, and utilise in a meaningful way, the tensions and oppositional assumptions, could be invaluable in bridging the very clear divide between experts by experience and experts by training. From this, I think also it possible that a more robust definition of, and desiderata for, coproduction could be given. Whilst it may appear that my view is a disparaging one when it comes to the value of this as a research approach, this is not the case. Rather, I think conceptual ambiguity and a lack of clear criterion to demarcate what is, or is not, an appropriate topic to undertake coproduction in relation to, are at the heart of the issues discussed here.

Relatedly, I would like to further explore expertise by experience, perhaps giving more robust conditions for inclusion as expert by experience in any project. This would not be to repeat discussions around the concept of expertise by experience, but rather to look at whether there ought to be pre-requisites which prevent such experts being treated as fungible, and ensuring that expectations are not set in ways which set vulnerable, and marginalised, individuals up to face epistemic harm, and undoubted disappointment.

A note on the opening quote

I began the introductory section of thesis with a quote from Audrey Lorde. This quote is, of course, infamous. Given the conclusions that this thesis has drawn however, I think it is a fitting explanation of the harms in coproduction. If you are so motivated as to think that psychiatry ought to be reformed, or perhaps even dismantled, then using the research methodologies which originate in psychiatry simply cannot be the approach you take, at least not if coproduction is the method being pursued. Researching within the academy, from a premise that psychiatric medicine does good, even if you manage to have your credibility settled, will not make room for views which oppose the very roots of psychiatric practice. In this sense, psychiatry can be understood as 'the master's house'. Coproduction, we might see as 'the master's tools'. As promising as the prospect of coproduction seems, it is a methodology which attempts to give over power, without considering what such giving over, or sharing, might require of its own epistemology. What this thesis has shown, is that when it comes to coproduction in mental ill health, "*the master's tools will never dismantle the master's house*", they simply cannot (Lorde, 1984: 112). Whether they should, as I've discussed here, is a matter that this thesis leaves open.

Bibliography

The Borderline Academic (2019) *Musings of a Mad Activist*. Independently Published.

Amador, X.F., Strauss, D.H., Yale, S.A. and Gorman, J.M. (1991) 'Awareness of Illness in Schizophrenia'. *Schizophrenia Bulletin,* vol.17, pp.113-132

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Anderson, L. (2017) 'Hermeneutical Impasses'. *Philosophical Topics,* vol.45(2) pp.1-19

Angermeyer, M.C., and Dietrich, S. (2006) 'Public beliefs about and attitudes towards people with mental illness: a review of population studies'. *Acta Psychiatrica Scandinavica,* vol.113 pp.163-179.

Angermeyer, M. C. and Matschinger, H. (2005). 'Causal beliefs and attitudes to people with schizophrenia: Trend analysis based on data from two population surveys in Germany.'. *The British Journal of Psychiatry,* vol.186 pp.331-334.

Anomaly, J. and Brennan, G. (2014) 'Social Norms, the 'Invisible Hand', and the Law'. *SSRN.* Available at: https://dx.doi.org/10.2139/ssrn.2527984

Arnstein, S.R. (1969) 'A Ladder of Citizen Participation'. *Journal of the American Institute of Planners,* vol. 35**,** pp.216-224.

Arnstein, S. R. (2019) 'A Ladder of Citizen Participation'. *Journal of the American Planning Association,* vol.85**,** pp.24-34.

Ásta (2018) *Categories We Live By: The Construction of Sex, Gender, Race, and Other Social Categories*. Oxford: Oxford University Press.

Barnes, B. and Bloor, D. (1982). 'Relativism, rationalism and the sociology of knowledge'. *In:* Hollis, M. and Lukes, S. (eds.) *Rationality and Relativism.* Oxford, UK: Basil Blackwell. pp.21-47.

Barnes, E.J. (2009). 'Disability and Adaptive Preference'. *Philosophical Perspectives,* vol.23**,** pp.1-22.

Barnes, E.J. (2016). *The Minority Body: A Theory of Disability,* Oxford, UK: Oxford University Press.

Barnes, E.J (2023). 'Trust, Distrust, and 'Medical Gaslighting''. *The Philosophical Quarterly,* vol.73**,** pp.649-676.

Bartunek, J. M. and Moch, M. K. (1994). 'Third-order Organizational Change and the Western Mystical Tradition' *Journal of Organizational Change Management,* vol.71**,** pp.24-41.

Beresford, D. P. and RUSSO, J. (2016). 'Supporting the Sustainability of Mad Studies and Preventing Its Co-option'. *Disability & Society,* vol.31**,** pp.270-274.

Beresford, D. P. and Russo, J. (eds.) (2022). *The Routledge International Handbook of Mad Studies,* Abingdon: Routledge.

Beresford, P. (2009). 'Developing a social model of madness and distress to underpin survivor research'. *In:* Sweeney, A. (ed.) *This is survivor research.* Ross-on-Wye: PCCS Books.

Beresford, P., Perring, R., Nettle, M. and Wallcraft, J. (2016). *From mental illness to a social model of madness and distress.* London: Shaping Our Lives.

Bergqvist, A. (2020). ‘Narrative Understanding, Value, and Diagnosis: A Particularist Account of Clinical Formulations and Shared Decision-making in Mental Health’. *Philosophy, Psychiatry, & Psychology,* vol.27**,** pp.149-167.

Bergqvist, A. (2023) ‘Shared Decision-Making and Relational Moral Agency: On Seeing the Person Behind the ‘Expert by Experience’ in Mental Health Research’. *Royal Institute of Philosophy Supplement,* 94**,** pp.173-200.

Bicchieri, C., Muldoon, R. and Sontuoso, A. (2023) ‘Social Norms’. *In:* Zalta, E. N. and Nodelman, U. (eds.) *The Stanford Encyclopedia of Philosophy.* Online. Available at: https://plato.stanford.edu/entries/social-norms/ Accessed: 11th November 2024

Blum, L. (2004) ‘Stereotypes And Stereotyping: A Moral Analysis’, *Philosophical Papers,* vol.33(3) pp.251-289

Blume, S. (2016) ‘In search of experiential knowledge.’ *Innovation: The European Journal of Social Science Research,* vol.30**,** pp.91-103.

Boardman, F. K. (2014) ‘Knowledge is power? The role of experiential knowledge in genetically 'risky' reproductive decisions.’ *Sociology of Health and Illness* vol.36(1) pp.137-50

Borkman, T. (1976) ‘Experiential Knowledge: A New Concept for the Analysis of Self-Help Groups.’ *Social Service Review,* vol.50(3)**,** pp.445-456.

Bouchard, M. (2019) ‘Turning Mad: a first-person account.’ *Journal of Ethics in Mental Health,* Open Volume 10.

Bovaird, T. (2007) ‘Beyond Engagement and participation: user and community co-production of public services.’ *Public Administration Review,* vol.67(5) pp.846-860.

Brown, L., and Strega, S. (2005) *Research as Resistance: Critical, Indigenous, and Anti-oppressive Approaches,* Toronto: Canadian Scholars’ Press

Brown, M.J. (2024) ‘For values in science: Assessing recent arguments for the ideal of value-free science.’ *Synthese*, vol.204(4) pp.1-31.

Brown, P. (1992) ‘Popular Epidemiology and Toxic Waste Contamination: Lay and Professional Ways of Knowing’. *Journal of Health and Social Behavior,* vol.33(3) pp.267-281.

Buchak, L. (2014) ‘Belief, credence, and norms.’ *Philosophical Studies,* vol.169(2)**,** pp.285-311.

Burge, T. (1993) ‘Content Preservation’. *Philosophical Review,* vol.102(4) pp.457-488.

Byskov, M. F. (2017) ‘Third Wave Development Expertise.’ *Oxford Development Studies,* vol.45(3) pp.352-65.

Byskov, M. F. (2021) ‘What Makes Epistemic Injustice an “Injustice”?’ *Journal of Social Philosophy,* vol.52(1) pp.114-131.

Cahill, A. J. (2011) *Overcoming objectification: A carnal ethics.* New York: Routledge.

Cahn, E. (2002) *No more throw away people: the co-production imperative.* Washington: Essential Books.

Campbell, P. (2022) ‘Speaking for Ourselves: An early UK survivor activist’s account.’ *In:* Beresford, D. P. and Russo, J. (eds.) *The Routledge International Handbook of Mad Studies.* Abingdon: Routledge pp.57-59.

Cardella, V. (2020) ‘Rationality in mental disorders: too little or too much?’ *European Journal of Analytic Philosophy,* vol.16 pp.13-36.

Carr, S. (2016). *Position paper: Are mainstream mental health services ready to progress transformative co-production?* Bath, UK: National Development Team for Inclusion [online] Available at: https://www.ndti.org.uk/assets/files/MH_Coproduction_position_paper.pdf Accessed: 12 October 2021.

Casman, M.T., Dierckx, D., Vranken, J., Deflandre, D., and Campaert, G. (2010) *Experts by Experience in Poverty and Social Exclusion: Innovation Players in the Belgian Federal Public Services,* Antwerp-Apeldoorn: Garant.

Castoriadis, C. (1997a) *World in fragments: Writings on politics, psychoanalysis and the imagination.* Palo Alto: Stanford University Press.

Castoriadis, C. (1997b) *The Castoriadis reader.* Oxford: Blackwell.

Castoriadis, C. (1998) *The Imaginary institution of society.* Cambridge, Mass: MIT Press.

Castoriadis, C. (2007) *Figures of the Unthinkable,* Palo Alto: Stanford University Press.

Castro, E.M., Van Regenmortel, T., Sermeus, W. and Vanhaect, K. (2018) ‘Patients’ experiential knowledge and expertise in health care: A hybrid concept analysis’, *Social Theory and Health* vol.17(3) pp.307-330

Cath, Y. (2018) ‘Knowing What It is Like and Testimony.’ *Australasian Journal of Philosophy,* vol.97(1) pp.105-120.

Chappell, Z. and Jeppsson, S. M. (2023) ‘Recovery without normalisation: It’s not necessary to be normal, not even in psychiatry.’ *Clinical Ethics,* vol.18(3) pp.298-305.

Chartonas, D., Kyratsous, M., Dracass, S., Lee, T. and Bhui, K. (2017) ‘Personality disorder: still the patients psychiatrists dislike?’ *British Journal of Psychiatry Bulletin* vol.41**,** pp.12-17.

Civan, A., McDonald, D. W., Unruh, K. T. and Pratt, W. (2009) ‘Locating Patient Expertise in Everyday Life.’ *GROUP ACM SIGCHI International Conference Support Group Work,* 2009**,** pp.291-300.

Civan, A. and Pratt, W. (2007) ‘Threading together patient expertise.’ *American Medical Informatics Association Annual Symposium* pp.140-4.

Coady, D. (2012) *What to Believe Now: Applying Epistemology to Contemporary Issues,* Malden, MA: Wiley-Blackwell.

Coady, D. (2017) ‘Epistemic Injustice as Distributive Injustice’ In: Kidd, I.J., Medina, J., and Pohlhaus Jr., G. (eds.) *The Routledge Handbook of Epistemic Injustice*. Abingdon: Routledge

Code, L. (1987) *Epistemic Responsibility,* Hanover: University Press of New England.

Code, L. (1991) *What Can She Know? Feminist Theory and the Construction of Knowledge,* New York: Cornell University Press.

Collins, H. (2014) *Are We All Scientific Experts Now?* Cambridge, UK: Polity Press.

Collins, H. and Evans, R. (2008) *Rethinking Expertise,* Chicago: University of Chicago Press.

Costa, L., Voronka, J., Landry, D., Reid, J., McFarlane, B., Reville, D. and Church, K. (2012) 'Recovering our Stories: A Small Act of Resistance.' *Studies in Social Justice* vol.6 pp.85-101.

Coulter, A. and Ellins, J. (2006) *Patient-focused interventions: a review of evidence*. London: The Health Foundation.

Crawford, M. J., Rutter, D., Manley, C., Weaver, T., Bhui, K., Fulop, N. and Tyrer, P. (2002) 'Systematic review of involving patients in the planning and development of health care.' *British Medical Journal,* vol.325**,** pp.1263.

Cresnshaw, K. (1991) 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color', *Stanford Law Review* vol.43(6) pp.1241-1299

Crenshaw, K. (2017) *On Intersectionality: Essential Writings*, New York: The New Press

Crichton, P., Carell, H. and Kidd, I. J. (2017) 'Epistemic injustice in psychiatry.' *British Journal of Psychiatry Bulletin,* vol.41**,** pp.65-70.

Cummins, J. and Miller, C. (2007) *Co-production, social captial and service effectiveness*. London: Office for Public Management.

David, A. S. (1990) 'Insight and psychosis.' *British Journal of Psychiatry,* vol.156**,** pp.798-808.

Davis, E. (2020) 'Typecasts, Tokens, and Spokespersons: A Case for Credibility Excess as Testimonial Injustice.' *Hypatia,* vol.31 pp.485-501.

Del Rocio Valdivia Quiroz, B. (2022) 'Shifting identities as reflective personal responses to political changes',: *In:* Beresford, D. P. and Russo, J. (eds.) *The Routledge International Handbook of Mad Studies.* Abingdon: Routledge, pp.41-52

Dell'Osso, L., Pini, S., Cassano, G. B., Mastrocinque, C., Seckinger, R. A., Saettoni, M., Papasogu, A., Yale, S. A. and Amador, X. F. (2002) 'Insight into illness in patients with mania, mixed mania, bipolar depression and major depression with psychotic features.' *Bipolar Disorder,* vol.4**,** pp.315-22.

Department for Health and Social Care (1999). *Saving Lives: Our Healthier Nation*. London, UK: The Stationary Office.

Department for Health and Social Care (2001) *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century*. London, United Kingdom: Department of Health.

Dings, R. and Tekin, Ş. (2022) 'A philosophical exploration of experience-based expertise in mental health care.' *Philosophical Psychology,* vol.36(3)**,** pp.1415-1434.

Dotson, K. (2012) 'A Cautionary Tale: On Limiting Epistemic Oppression.' *Frontiers: A Journal of Womens Studies,* vol.33**,** pp.24-47.

Dotson, K. (2014). 'Conceptualizing Epistemic Oppression.' *Social Epistemology,* vol.28(2)**,** pp.115-138.

Dreyfus, H.L. and Dreyfus, S.E. (1986) *Mind over Machine: The Power of Human Intuition and Expertise in the Era of the Computer,* New York: Free Press

DuBrul, S. A. (2014) ‘The Icarus Project: a counter narrative for psychic diversity.’ *Journal of Medical Humanities.,* vol.35(3)**,** pp.257-271.

Dumez, V. and L’Espérance, A. (2024) ‘Beyond experiential knowledge: a classification of patient knowledge.’ *Social Theory & Health,* vol.22(3)**,** pp.173-186.

Edwards, R. B. (1981) ‘Mental Health as Rational Autonomy.’ *Journal of Medicine and Philosophy,* vol.6**,** pp.309-322.

Ericsson, K.A., Krampe, R.T., and Tesch-Romer, C. (1993) ‘The Role of Deliberate Practice in the Acquisition of Expert Performance’, *Psychological Review* vol.100(3) pp.363-406

Ericsson, K. A. and Pool, R. (2016) *Peak: Secrets from the New Science of Expertise,* Boston, MA: Mariner.

Evers, M. M. (2017) ‘On Transgression.’ *International Studies Quarterly,* vol.61(4)**,** pp.786–794.

Farr, M. (2018) ‘Power dynamics and collaborative mechanisms in coproduction and co-design processes.’ *Critical Social Policy,* vol.38(4)**,** pp.623-644.

Faulkner, A. (2017) ‘Survivor research and Mad Studies: the role and value of experiential knowledge in mental health research.’ *Disability & Society,* vol.32(4)**,** pp.500-520.

Faulkner, P. (2021) ‘Communicating your point of view.’ *European Journal of Philosophy,* vol.30(2)**,** pp.661-675.

Flinders, M., Wood, M. and Cunningham, M. (2016) ‘The politics of co-production: risks, limits and pollution.’ *Evidence & Policy,* 12(2)**,** pp.261-279.

Foucault, M. (1988) *Madness and Civilization: A History of Insanity in the Age of Reason,* New York, Random House.

Foucault, M. (1994) Psychiatric Power. *In:* Rabinow, P. (ed.) *Ethics: Subjectivity and Truth.* New York: The New Press.

Frances, A. (2014). Stigmatizing and Shunning the Severely Ill. *Psychiatric Times* [Online], 31. Available: https://www.psychiatrictimes.com/view/stigmatizing-and-shunning-severely-ill# [Accessed 30th January 2025].

Fransman, J. (2018) ‘Charting a course to an emerging field of 'research engagement studies': A conceptual meta-synthesis.’ *Research for All,* vol.2(2) pp.185-229.

Fricker, E. (2006) ‘Testimony and Epistemic Autonomy.’ *In:* Lackey, J. and Sosa, E. (eds.) *The Epistemology of Testimony.* Oxford: Oxford University Press.

Fricker, M. (2007) *Epistemic injustice: power and the ethics of knowing,* New York: Oxford University Press.

Friedman, J (forthcoming) ‘Zetetic Epistemology’ in: Reed, B., and Flowerree, A.K (eds.) *Towards an Expansive Epistemology: Norms, Action, and the Social Sphere*, New York: Routledge

Fulford, K. W. M. (2004) ‘Ten principles of values-based medicine (VBM)’. *In:* Schramme, T. and Thome, J. (eds.) *Philosophy and Psychiatry.* Berlin: De Grutyer.

Fulford, K. W. M. (2008) ‘Values-based practice: a new partner to evidence-based practice and a first for psychiatry?’ *Mens Sana Monographs,* vol.6**,** pp.10-21.

Gatens, M. (1995) *Imaginary bodies: Ethics, power and corporeality,* New York: Routledge.

Gatens, M. and Lloyd, G. (1999) *Collective imaginings: Spinoza, past and present,* New York: Routledge.

Glasby, J. and Beresford, P. (2006) 'Commentary and Issues : Who knows best? Evidence-based practice and the service user contribution.' *Critical Social Policy,* vol.26**,** pp.268-284.

Goetze, T.S. (2020) 'Hermeneutical Dissent and the Species of Hermeneutical Injustice' *Hypatia* vol.33(1) pp.73-90

Goldman, A. (1999) *Knowledge in a social world,* Oxford: Oxford University Press.

Goldman, A. (2001) 'Experts: Which ones should you trust?' *Philosophy and Phenomenological Research,* vol.63**,** pp.85-109.

Goldman, A. (2016) 'Expertise', *Topoi* vol.37(1) pp.3-10.

Gopal, D.P., Chetty, U., O'Donnell, P., Gajria, C., and Blackadder-Weinstein, J. (2021) 'Implicit bias in healthcare: clinical practice, research and decision making', *Future Healthcare Journal* vol.8(1) pp.40-48

Greenhalgh, T. (2009) 'Chronic illness: Beyond the expert patient.' *British Medical Journal,* vol.338 (March)**,** pp.629-631.

Grice, H.P. (1989) *Studies in the Way of Words*, Cambridge, MA: Harvard University Press

Guidry-Grimes, L. (2015) 'Modelling psychiatric disability.' *Journal of Evaluation in Clinical Practice,* vol.21(3)**,** pp.490-5.

Guidry-Grimes, L. (2019) 'Ethical complexities in assessing patients' insight', *Journal of Medical Ethics* vol.45(3) pp.178-182

Gurung, D., Poudyal, A., Wang, Y. L., Neupane, M., Bhattarai, K., Wahid, S. S., Aryal, S., Heim, E., Gronholm, P., Thornicroft, G. and Kohrt, B. (2022) 'Stigma against mental health disorders in Nepal conceptualised with a 'what matters most' framework: a scoping review.' *Epidemiology and Psychiatric Sciences,* vol.31**,** e11.

Handa, A. and Fulford, B. K. W. M. (2023) Values-Based Practice: A Theory-Practice Dynamic for Navigating Values and Differences in Health Care. *Royal Institute of Philosophy Supplement, 94*, pp.219-244

Harcourt, E. (2021) 'Epistemic injustice, children and mental illness'. *Journal of Medical Ethics,* vol.47(11)**,** pp.729-735.

Harcourt, E. and Crepaz-Keay, D. (2023) 'Co-Production is Good, but Other Things are Good Too.' *Royal Institute of Philosophy Supplement,* 94**,** 157-172.

Harman, G. (1986) *Change in View,* Cambridge, Mass: MIT Press.

Hartzler, A. and Pratt, W. (2011) 'Managing the personal side of health: How patient expertise differs from the expertise of clinicians', *Journal of Medical Internet Research* vol.13(3)

Harvey, A., Watkins, E., Mansell, W. and Shafran, R. (2004) *Cognitive Behavioural Processes across Psychological Disorders: A transdiagnostic approach to research and treatment,* Oxford: Oxford University Press.

Haslanger, S. (2012) *Resisting Reality: Social Construction and Social Critique,* Oxford: Oxford University Press

Haslanger, S. (2017) 'Objectivity, epistemic objectification, and oppression'. *In:* Kidd, I. J., Medina, J. and Pohlhaus Jr, G. (eds.) *The Routledge Handbook of Epistemic Injustice.* Abingdon, Oxfordshire: Routledge, pp.279-290.

Hawley, K. (2010) 'Testimony and knowing how.' *Studies in History and Philosophy of Science,* 41(2010), pp.397-404.

Hills, A. (2009) 'Moral testimony and moral epistemology'. *Ethics,* vol.120, pp.94-127.

Holman, H. and Lorig, K. (2004) 'Patient self-management: A key to effectiveness and efficiency in care of chronic disease.' *Public Health Reports,* vol.119(3), pp.239-243.

Hookway, C. (2001) 'Epistemic Akrasia and Epistemic Virtue.' *In:* Fairweather, A. and Zagzebski, L. T. (eds.) *Virtue Epistemology: Essays on Epistemic Virtue and Responsibility.* New York: Oxford University Press, pp.178-199.

Hopkins, R. (2007) 'What is wrong with moral testimony?' *Philosophy and Phenomenological Research,* vol.74(3), pp.611-634.

Hopkins, R. (2011) 'How to be a pessimist about aesthetic testimony.' *The Journal of Philosophy,* vol.108(3), pp.138-157.

HydÈn, L.C., and Sachs, L. (1998) 'Suffering, hope and diagnosis: on the negotiation of chronic fatigue syndrome', *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* vol.2(2) pp.175-193

Iedema, R. and Carroll, K. (2011) 'The "clinalyst."' *Journal of Organizational Change Management,* vol.24(2), pp.175-190.

Jackson, E. (2022) 'On the independence of belief and credence.' *Philosophical Issues,* vol.32, pp.9-31.

Jackson, F. (1982) 'Epiphenomenal Qualia.' *The Philosophical Quarterly,* vol.32, pp.127-136.

Joseph, A. (2022) 'The Subjects of Oblivion'. *In:* Beresford, D. P. and Russo, J. (eds.) *The Routledge International Handbook of Mad Studies.* Abingdon: Routledge, pp.135-141.

Kenny, A., Bizumic, B. and Griffiths, K. M. (2018) 'The Prejudice towards People with Mental Illness (PPMI) scale: structure and validity.' *BMC Psychiatry,* vol.18, p.293.

Kidd, I.J., Medina, J., and Pohlhaus Jr, G. (2017) (ed.) *The Routledge Handbook of Epistemic Injustice,* Abingdon: Routledge

Kidd, I. J., Spencer, L. and Carel, H. (2022) 'Epistemic injustice in psychiatric research and practice.' *Philosophical Psychology,* vol.38(2), pp.1-29.

Kidd, I. J., Spencer, L. and Harris, E. (2023) 'Epistemic Injustice Should Matter to Psychiatrists.' *Philosophy of Medicine,* 4(1).

Kousoulis, A. (2019) 'Why the language we use to describe mental health matters.' [online] Available at: https://www.mentalhealth.org.uk/explore-mental-health/blogs/why-language-we-use-describe-mental-health-matters 2022 (Accessed: 20 September 2023).

Krendl, A. C. and Freeman, J. B. (2019) ‘Are mental illnesses stigmatized for the same reasons? Identifying the stigma-related beliefs underlying common mental illnesses.’ *Journal of Mental Health,* vol.28(3), pp.267-275.

Kukla, R. (2007) ‘How do patients know?’ *Hastings Centre Report,* vol.37(5), pp.27-35.

Kultgen, J. (1995) *Autonomy and intervention: Parentalism in the caring life.* Oxford: Oxford University Press.

Lakeman, R. (2010) ‘Epistemic injustice and the mental health service user.’ *International Journal of Mental Health Nursing,* vol.19(3), pp.151-3.

Lambert, N. and Carr, S. (2018) ‘'Outside the Original Remit': Co-production in UK mental health research, lessons from the field.’ *International Journal of Mental Health Nursing,* vol.27(4), pp.1273-1281.

Lee, Y. Y. and Lin, J. L. (2010) ‘Do patient autonomy preferences matter? Linking patient-centered care to patient-physician relationships and health outcomes.’ *Social Science and Medicine,* vol.71(10), pp.1811-8.

Lewis, A. (1934) ‘The psychopathology of insight.’ *Journal of Medical Psychology,* vol.14, pp.332-348.

Lewis, D. (1999) ‘What experience teaches.’ *In:* Lewis, D. (ed.) *Papers in metaphysics and epistemology.* Cambridge: Cambridge University Press.

Liberman, R. P. and Kopelowicz, A. (2005) ‘Recovery From Schizophrenia: A Concept in Search of Research.’ *Psychiatric Services,* vol.56(6), pp.735-742.

Liegghio, M. (2013) ‘A denial of being: psychiatrization as epistemic violence.’ *In:* LeFrancois, B. A., Menzies, R. and Reaume, G. (eds.) *Mad matters: A critical reader in Canadian Mad Studies.* Toronto: Canadian Scholars’ Press, pp.122-129.

Lindvall-Östling, M. (2024) ‘“If you are aware of something, you can do something about it”: Investigating the lasting effects of an implicit bias training activity.’ *Teaching and Teacher Education,* vol.140(2024) pp.1-9.

Lorde, A. (1984) ‘The Master’s Tools Will Never Dismantle the Master’s House.’ In: Lorde, A. (ed.) *Sister Outsider: Essays and Speeches.* Berkeley, CA: Crossing Press, pp.110-114.

Maconick, L., Ikhtabi, S., Broeckelmann, E., Pitman, A., Barnicot, K., Billings, J., Osborn, D. and Johnson, S. 2023. ‘Crisis and acute mental health care for people who have been given a diagnosis of a ‘personality disorder’: a systematic review.’ *BMC Psychiatry,* vol.23(720) pp.1-31.

Malantes, K. (2011) *What it is like to go to war.,* New York: Atlantic Monthly Press.

Markova, I. S. and Berrios, G. E. (1992). ‘The meaning of insight in clinical psychiatry’. *British Journal of Psychiatry,* vol.160(6), pp.850-60.

Martin Alcoff, L. (2010) ‘Sotomayor’s Reasoning.’ *The Southern Journal of Philosophy,* vol.48(1), pp.122-138.

Mason, R. (2011) ‘Two Kinds of Unknowing.’ *Hypatia,* vol.26(2), pp.294-207.

McGlynn, A. (2019) ‘Epistemic Objectification as the Primary Harm of Testimonial Injustice.’ *Episteme,* vol.18(2), pp.160-176.

Medina, J. (2011) 'The Relevance of Credibility Excess in a Proportional View of Epistemic Injustice: Differential Epistemic Authority and the Social Imaginary', *Social Epistemology* vol.25(1) pp.15-35

Medina, J. (2012) 'Hermeneutical Injustice and Polyphonic Contextualism: Social Silences and Shared Hermeneutical Responsibilities.' *Social Epistemology,* vol.26(2)**,** pp.201-220.

Medina, J. (2013) *The Epistemology of Resistance: Gender and Racial Oppression, Epistemic Injustice, and Resistant Imaginations,* New York: Oxford University Press.

Menon, T. and Stegenga, J. (2023) 'Sisyphean science: why value freedom is worth pursuing.' *European Journal for Philosophy of Science,* vol.13(4): 48.

Menzies, R., LeFrancois, B. A. and Reaume, G. (2013). 'Introducing mad studies.' *In:* LeFrancois, B. A. Menzies, R., and Reaume, G. (eds.) *Mad Matters: A Critical Reader in Canadian Mad Studies.* Toronto: Canadian Scholars' Press pp.1-22.

Meskin, A. (2004) 'Aesthetic testimony: What can we learn from others about beauty and art?' *Philosophy and Phenomenological Research,* vol.64(1)**,** pp.65-91.

Metzen, H. (2024) 'Vigilant trust in scientific expertise', *European Journal for Philosophy of Science* vol.14(4).

Mockford, C., Staniszewska, S., Griffiths, F. and Herron-Marx, S. (2012) 'The impact of patient and public involvement on UK NHS health care: a systematic review.' *International Journal for Quality in Health Care,* vol.24(1)**,** pp.28-38.

Montgomery, K. (2006) *How Doctors Think: Clinical Judgement and the Practice of Medicine,* Oxford: Oxford University Press.

Myers, D. and Dewall, N. (2015) *Psychology,* New York: Worth Publishers.

Newbigging, K. and Ridley, J. (2018) 'Epistemic struggles: The role of advocacy in promoting epistemic justice and rights in mental health.' *Social Science & Medicine,* vol.219**,** pp.36-44.

Nichols, T. (2017) *The Death of Expertise: The Campaign Against Established Knowledge and Why it Matters,* New York: Oxford University Press.

Nickerson, R. S. (1998) 'Confirmation Bias: A Ubiquitous Phenomenon in Many Guises.' *Review of General Psychology,* vol.2(2)**,** pp.175-220.

Nussbaum, M. C. (2006) 'Objectification.' *Philosophy & Public Affairs,* vol.24(4)**,** pp.249-291.

Okoroki, C., MacKay, T., Robotham, D., Beckford, D. and Pinfold, V. (2023) 'Epistemic injustice and mental health research: A pragmatic approach to working with lived experience expertise.' *Frontiers in Psychiatry,* vol.14**.**

Oliver, K., Kothari, A. and Mays, N. (2019) 'The dark side of coproduction: do the costs outweigh the benefits for health research?' *Health Research Policy and Systems,* vol.17(33).

Ortega, M. (2006) 'Being Lovingly, Knowingly Ignorant: White Feminism and Women of Color.' *Hypatia,* vol.21(3)**,** pp.56-74.

Ostrom, E. (1996) 'Crossing the great divide: coproduction, synergy, and development.' *World Development,* vol.24(6)**,** pp.1073-1087.

Papadaki, E. (2024). ‘Feminist Perspectives on Objectification.’ *The Stanford Encyclopedia of Philosophy* (Summer 2024 edition) Zalta, E., and Nodelman, U. (eds.) Available at: https://plato.stanford.edu/archives/sum2024/entries/feminism-objectification/ [Accessed: 10 October 2024]

Parsons, T. (1951) *The social system,* London: Routledge and Kegan Paul.

Paterson, B. L., Russell, C. and Thorne, S. (2001) ‘Critical analysis of everyday self-care decision making in chronic illness’. *Journal of Advanced Nursing,* vol.35(3), pp.335-41.

Penney, D. and Prescott, L. (2016) ‘The co-optation of survivor knowledge: The danger of substituted values and voice.’ *In:* Russo, J. and Sweeney, A. (eds.) *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies.* Monmouth: PCCS Books pp.35-45.

Peters, U. (2020) ‘What Is the Function of Confirmation Bias?’ *Erkenntnis,* vol.87(3), pp.1351-1376.

Pohlhaus Jr., G. (2011) Relational Knowing and Epistemic Injustice: Toward a Theory of ‘Willful Hermeneutical Ignorance.’. *Hypatia,* vol.27(4), pp.715-35.

Pohlhaus Jr., G. (2013) ‘Discerning the Primary Epistemic Harm in Cases of Testimonial Injustice’ *Social Epistemology* vol.28(2) pp.99-114

Pols, J. (2013) ‘Knowing Patients: Turning patient knowledge into science.’ *Science, Technology, and Human Values,* vol.39(1), pp.73-97.

Porter, R. (1987) *A social history of madness,* London: George Weidenfeld and Nicholson Ltd.

Price, M. J. (1993) ‘Exploration of body listening: Health and physical self-awareness in chronic illness’ *Advances in Nursing Science,* vol.15(4), pp.37-52.

Quast, C. (2016) ‘Expertise: A Practical Explication.’ *Topoi,* vol.37(1), pp.11-27.

Radden, J. (1992) ‘Planning for mental disorder: Buchanan and Brock on advance directives in psychiatry.’ *The Journal of Social Theory and Practice,* vol.18(2), pp.165-186.

Radden, J. (1994) ‘Second thoughts : Revoking decisions over one’s own future.’ *Philosophy and Phenomenological Research,* vol.54(4), pp.787-801.

Radden, J. (1996) *Divided minds and successive selves: Ethical issues in disorders of identity and personality.* Cambridge, MA: MIT Press.

Radden, J. (2003) ‘Forced Medication, Patients' Rights and Values Conflicts.’ *Psychiatry, Psychology and Law,* vol.10(1), pp.1-11.

Radden, J. and Sadler, J. Z. (2010) *The Virtuous Psychiatrist: Character Ethics in Psychiatric Practice,* Oxford: Oxford University Press.

Radden, J. H. (2012) ‘Recognition rights, mental health consumers and reconstructive cultural semantics.’ *Philosophy, Ethics, and Humanities in Medicine,* vol.7(6)

Rashed, M.A. (2019) *Madness and the demand for recognition: A philosophical inquiry into identity and mental health activism,* Oxford: Oxford University Press.

Realpe, A. and Wallace, L. M. (2010) *What is CoProduction*? London: The Health Foundation.

Reaume, G. (2022) ‘How is Mad Studies different from anti-psychiatry and critical-psychiatry?’ *In:* Beresford, D. P. and Russo, J. (eds.) *The Routledge International Handbook of Mad Studies.* Abingdon: Routledge pp.98-107.

Regier, D., Kuhl, E., Kupfer, J. and McNultry, J. (2010) ‘Patient Involvement in the Development of DSM-V.’ *Psychiatry: Interpersonal and Biological Processes,* vol.73(4)**,** pp.308-310.

Resnik, D.B. and Elliott, K.C. (2019) ‘Value-entanglement and the integrity of scientific research.’ *Studies in the History of the Philosophy of Science,* vol.75*,* pp.1-11.

Rogers, A. and Pilgrim, D. (1993) ‘Service users’ views of psychiatric treatment.’ *Sociology of Health and Illness,* vol.15**,** pp.612-631.

Rose, D. (2009). ‘Survivor-based knowledge.’ *In:* Beresford, D. P., Faulkner, A., Sweebet, A., Rose, D. and Nettle, M. (eds.) *This is survivor research.* Monmouth: PCCS Books.

Rose, D., Thornicroft, G., Pinfold, V. and Kassam, A. (2007) ‘250 labels used to stigmatise people with mental illness.’ *BMC Health Services Research,* vol.7(1).

Russo, J. (2014) ‘Mental health service users in research: critical sociological perspectives.’ *Disability & Society,* vol.29(3)**,** pp.498-500.

Russo, J. (2022) ‘The international foundations of Mad Studies: Knowledge generated in collective action.’ *In:* Beresford, D. P. and Russo, J. (eds.) *The Routledge International Handbook of Mad Studies.* Abingdon: Routledge, pp.19-29.

Russo, J. (2023) ‘Psychiatrization, assertions of epistemic injustice, and the question of agency.’ *Frontiers in Sociology,* vol.8: 2023.

Sanati, A. and Kyratsous, M. (2015) ‘Epistemic injustice in assessment of delusions.’ *Journal of Evaluation in Clinical Practice,* vol.21(3)**,** pp.479-85.

Scholz, O. R. (2016) ‘Symptoms of Expertise: Knowledge, Understanding and Other Cognitive Goods.’ *Topoi,* vol.37(1)**,** pp.29-37.

Scrutton, A. P. (2017) ‘Epistemic injustice and mental illness.’ *In:* Kidd, I. J., Medina, J. and Pohlhaus Jr., G. (eds.) *The Routledge Handbook of Epistemic Injustice.* London: Routledge, pp.347-355.

Scull, A. (1981) *Madhouses, Mad-doctors, and Madmen: The Social History of Psychiatry in the Victorian Era.* Philadelphia: University of Pennsylvania Press.

Scull, A. (2015) *Madness in Civilization: A Cultural History of Insanity, from the Bible to Freud, from the Madhouse to Modern Medicine,* Princeton, NJ: Princeton University Press

Sen, D. and Sexton, A. (2016) ‘More voice, less ventriloquism: Building a mental health recovery archive.’ *In:* Russo, J. and Sweeney, A. (eds.) *Searching for a rose garden: Challenging psychiatry, fostering Mad Studies.* Monmouth, UK: PCCS Books.

Sharma, A. E., Knox, M., Mleczko, V. L. and Olayiwola, J. N. (2017) ‘The impact of patient advisors on healthcare outcomes: a systematic review.’ *BMC Health Services Research,* vol.17**,** Article no.693.

Shaw, J. and Baker, M. (2004) ‘“Expert Patient” – Dream or Nightmare?’ *British Medical Journal,* vol.328**,** pp.723-724.

Shimrat, I. (2022) ‘Reflections on survivor knowledge and Mad Studies.’ *In:* Beresford, D. P. and Russo, J. (eds.) *The Routledge International Handbook of Mad Studies.* Abingdon: Routledge, pp.53-56.

Slay, J. and Stephens, L. (2013) ‘Co-production in mental health: A literature review.’ London: new economics foundation.

Sosa, E. (2015) *Judgment and Agency,* Oxford: Oxford University Press.

Sosa, E. (2021) *Epistemic Explanations: A Theory of Telic Normativity, and What It Explains,* Oxford: Oxford University Press.

Spencer, L. and Kidd, I. J. (2023) ‘‘The Hermeneutic Problem of Psychiatry’ and the Co-Production of Meaning in Psychiatric Healthcare.’ *Royal Institute of Philosophy Supplement,* 94**,** pp.103-131.

Staffel, J. (2018) ‘How do Beliefs Simplify Reasoning? *Noûs,* vol.53(4)**,** pp.937-962.

Stammers, S. and Pulvermacher, R. (2020) ‘The value of doing philosophy in mental health contexts.’ *Medicine, Health Care and Philosophy,* vol.23(4)**,** pp.743-752.

Steen, T., Brandsen, T., and Verschuere, B. (2018) ‘The Dark Side of Co-Creation and Co-Production’ in: Brandsen, T., Verscheuere, B., and Steen, T. (eds.) *Co-Production and Co-Creation: Engaging Citizens in Public Services,* New York: Routledge.

Stramondo, J. A. (2021) ‘Bioethics, Adaptive Preferences, and Judging the Quality of a Life with Disability.’ *Social Theory and Practice,* vol.47(1)**,** pp.199-220.

Sullivan, S., and Tuana, N. (2007) *Race and epistemologies of ignorance*, Albany, NY: SUNY Press

Sweeney, A. (2015) ‘Sociology and survivor research: An introduction.’ *In:* Staddon, D. P. (ed.) *Mental health service users in research: Critical sociological perspectives.* Bristol: Policy Press.

Sweeney, A. (2016) ‘Why Mad Studies Needs Survivor Research and Survivor Research Needs Mad Studies’ *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice,* vol.5(3)**,** pp.36-61.

Szasz, T. (1974) *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct,* New York: Harper.

Taylor, C. (2004) *Modern Social Imaginaries,* Durham, NC: Duke University Press.

Tekin, Ş.and Outram, S.M. (2018) ‘Overcoming mental disorder stigma: A short analysis of patient memoirs’, *Journal of Evaluation in Clinical Practice* vol. 24(5) pp.1114-1119

Tekin, Ş. (2020) ‘Patients as Experience-Based Experts in Psychiatry: Insights from the Natural Method’. *In:* Nahmias, E., Polger, T. W. and Zhao, W. (eds.) *The Natural Method: Ethics, Mind & Self, Themes from the Work of Owen Flanagan.* Cambridge, MA: MIT Press, pp.79-91.

Tekin, Ş. (2022) ‘Participatory Interactive Objectivity in Psychiatry.’ *Philosophy of Science,* vol.89(5)**,** pp.1166-1175.

Tekin, Ş. (2023) ‘Philosophy of Psychiatry Meets Experimental Philosophy: Expertise Naturalized.’ *In:* Hens, K. and De Block, A. (eds.) *Advances in Experimental Philosophy of Medicine.* London: Bloomsbury Academic, pp.305-322.

Thompson, J., Bissell, P., Cooper, C., Armitage, C. J. and Barber, R. (2012) 'Credibility and the 'professionalized' lay expert: reflections on the dilemmas and opportunities of public involvement in health research.' *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine,* vol.16(6) pp.602-618.

Thompson, L. and McCabe, R. (2018) 'How Psychiatrists Recommend Treatment and Its Relationship with Patient Uptake.' *Health Communication,* vol.33(11), pp.1345-1354.

Toole, B. (2020) 'From Standpoint Epistemology to Epistemic Oppression', *Hypatia* vol.34(4) pp.598-618

Townley, C. (2003) 'Trust and the Curse of Cassandra (An Exploration of the Value of Trust).' *Philosophy in the Contemporary World,* vol.10(2), pp.105-111.

Tuana, N. (2004) 'Coming to understand: Orgasm and the epistemology of ignorance.' *Hypatia,* vol.19(1), pp.194-232.

Tuana, N. (2006) 'The speculum of ignorance: The women's health movement and epistemologies of ignorance.' *Hypatia,* vol.21(3), pp.1-19.

Tyreman, S. (2005) 'An expert in what?: the need to clarify meaning and expectations in "The Expert Patient".' *Medicine, Health Care and Philosophy,* vol. 8(2), pp.153-157.

Vaditya, V. (2018) 'Social Domination and Epistemic Marginalisation: towards Methodology of the Oppressed', *Social Epistemology* vol.32(4) pp.272-285

Van Kleef, G. A. (2024) 'Bottom-up influences on social norms: How observers' responses to transgressions drive norm maintenance versus change.' *Current Opinion in Psychology,* vol.60 (December 2024).

Vela, M. B., Erondu, A. I., Smith, N. A., Peek, M. E., Woodruff, J. N. and Chin, M. H. (2022) 'Eliminating Explicit and Implicit Biases in Health Care: Evidence and Research Needs.' *Annual Review of Public Health,* vol.43, pp.477-501.

Vintiadis, E. (2016) 'The Irrationality Within Us'. *Scientific American* [Online]. Available from: https://www.scientificamerican.com/blog/mind-guest-blog/the-irrationality-within-us/ (Accessed: 27th September 2024)

Voronka, J. (2016) 'The politics of 'people with lived experience': Experiential authority and the risks of strategic essentialism.' *Philosophy, Psychiatry & Psychology,* vol.23(3-4), pp.189-201.

Wakefield, J. C. (1992a) 'The concept of mental disorder: On the boundary between biological facts and social values.' *American Psychologist,* vol.47(3), pp.373-388.

Wakefield, J. C. (1992b) 'Disorder as harmful dysfunction: A conceptual critique of DSM-III-R's definition of mental disorder.' *Psychological Review,* vol.99, pp.232-247.

Walsh, B. T. (2013) 'The enigmatic persistence of anorexia nervosa.' *American Journal of Psychiatry,* vol.170(5), pp.477-84.

Walter, I. C., Nutley, S. M. and Davies, H. T. O. (2003) 'Models of research impact - a cross sector literature review.' St Andrews: University of St Andrews.

Watson, J. C. (2016) 'The Shoulders of Giants: A Case for Non-veritism about Expert Authority.' *Topoi,* vol.37(1), pp.39-53.

Watson, J. C. (2020) *Expertise: A Philosophical Introduction,* London, UK: Bloomsbury.

Watson, J. C. (2023) 'Patient Expertise and Medical Authority: Epistemic Implications for the Provider-Patient Relationship.' *Journal of Medicine and Philosophy,* vol.49(1) pp.58-71.

Weisberg, J. (2020) 'Belief in Psyontology.' *Philosopher's Imprint,* vol.20(11)**,** pp.1-27.

White, W. L. (2022) 'Re-Writing the Master Narrative: A Prequisite for Mad Liberation.' *In:* Beresford, D. P. and Russo, J. (eds.) *The Routledge International Handbook of Mad Studies.* Abingdon: Routledge pp.76-89.

Wilde A. (2023) 'Co-Production and Structural Oppression in Public Mental Health'. *Royal Institute of Philosophy Supplement, 94,* pp.133-156.

Williams, O., Sarre, S., Papoulias, S.C., Knowles, S., Robert, G., Beresford, P., Rose, D., Carr, S., Kaur, M., and Palmer, V.J. (2020) 'Lost in the shadows: reflections on the dark side of co-production', *Health Research Policy and Systems* vol.18:43

Wodzinski, M. and Moskalewicz, M. (2023) 'Mental Health Experts as Objects of Epistemic Injustice-The Case of Autism Spectrum Condition.' *Diagnostics,* vol.13(5).

Zagzebski, L. T. (2020) *Epistemic Values: Collected Papers in Epistemology,* Oxford: Oxford University Press

Appendix 1 – Works published

The below article was published as follows: Wilde A. (2023) Co-Production and Structural Oppression in Public Mental Health. *Royal Institute of Philosophy Supplement*. vol.94. pp.133-156. doi:10.1017/S1358246123000231

Abstract

Co-production, in the field of mental health, aims to bring together academic and clinical researchers and those with lived experience. Often, research projects informed by this methodology involve the meeting of opposing attitudes, whether to the legitimacy of psychiatry, determinants of mental ill health, or the most appropriate interventions. This has meant that whilst some have reported positive experiences of co-production, many people with lived experience of mental ill health, sometimes referred to as 'experts by experience' (EbE), report harms which have taken place or been perpetuated during co-produced research projects. In the literature, nearly always, this is understood as a kind of epistemic injustice in Miranda Fricker's sense. In this paper, I argue that whilst Fricker's view does provide a plausible explanation of what's at play, we can gain more insight into the structural factors which exclude EbE by applying a framework of epistemic oppression. By highlighting the systemic and structural factors which work to keep certain knowers and their contributions out of our collective epistemic resources, we begin to understand the enormity of the task required to redress injustices in our knowledge production systems.

Co-production and structural oppression in public mental health

§1. Introduction

Coproduction, as a relatively nascent research methodology in public mental health, aims to bring together academic and clinical researchers, with those who have lived experience of mental ill health. It is posited as a revolutionised approach to research, including those who have traditionally been research*ed* as equal members of the research team. These research projects take place across mental health disciplines such as public health, primary care design, digital mental health interventions, etc., and bring together opposing attitudes to the legitimacy of psychiatry, to the determinants of mental ill health, and to what we ought to be able to value. This has meant that whilst some have reported positive experiences of coproduction, many people with lived experience of mental ill health, sometimes referred to as 'experts by experience' (EbE) , report harms which have taken place or been perpetuated during coproduced research projects. Almost always, in the literature these harms are described as being a kind of epistemic injustice, drawing upon the work of Miranda Fricker (2007). In this paper, I'll explain how epistemic injustice provides a plausible explanation of the harms done to experts by experience in their capacity as authoritative knowers. I'm going to argue, though, that we might better under such exclusionary and harmful practices through the lens of epistemic oppression. Epistemic oppression, in Kristie Dotson's (2014) sense, provides a distinct epistemic perspective which allows us to highlight systemic and structural factors which work to keep certain knowers, and their contributions out of our collective epistemic resources. The harms, I'll argue, are still epistemic in nature, but by extending beyond individual-level prejudice, we're able to see what would be required that coproduction be done well.

§2. Epistemic injustice: an obvious framework?

Oftentimes, discussions of harms perpetuated by the research environment are understood as a kind of *epistemic injustice*, in as much as experts by experience are often not treated as the right kind of knowers, despite being believed to have valuable knowledge of research foci. And this sense of a harm being done to someone in their capacity as a knower perhaps seems apt, given the focus of this paper. Co-production invites individuals with lived experience, –understood as 'experts by experience', in many cases– to contribute to research from the earliest stages based upon their first-hand knowledge of the topic being examined. Attempts to further and to deepen our knowledge of some topic or other, just are epistemic in nature.

Miranda Fricker (2007) developed what is the most widely accepted framework of *epistemic injustice*, to explain the phenomena of individuals, often from marginalised social positions or groups, routinely being dismissed or disbelieved. For epistemic injustice to occur, a judgement of an individual as a less credible knower (either relative to the credibility I assign to myself, or compared to a competing source of information) is made, based on a prejudicial stereotype. Typically, this stereotype takes the form of a negative identity prejudice. On Fricker's view, we routinely use heuristic aids, such as stereotypes, as psychological shortcuts, that aid our judgement and reasoning (Fricker, 2007). Consider the following example. If someone is invited to testify at a trial as an 'expert witness' and begins their testimony with a list of their academic achievements, I may assign what they say a greater level of importance than 'bystanders', due to my prejudicial belief that academic qualification makes one particularly well suited to evidence-giving. In Fricker's terminology, I rely on my own heuristic aid concerning expert witnesses, which assigns high levels of credibility to academic 'experts', and take what the expert witness says at face value. What goes 'wrong' in cases of epistemic injustice, is that the stereotypes upon which I rely are almost always negative or ethically noxious in nature. These stereotypes are inversely correlated with judgements regarding competence and credibility. If my interlocutor belongs to a ‘group’ against whom I hold a negative identity prejudice (whether conscious or not) I may deflate or decrease the level of legitimacy I assign to what they say (Fricker, 2007).

Being perceived as ‘ill’ in any sense, physical or mental, can heighten susceptibility to experiencing this deflation of one’s credibility as a knower. Carel and Kidd have argued that individuals with physical illnesses are more vulnerable to epistemic injustices than those in good health (Carel and Kidd, 2014; 2017). And mental ill health remains a topic subject to particularly pernicious and deeply entrenched negative stereotypes, such that vulnerabilities to being undermined or dismissed as a credible ‘knower’ are compounded (Crichton, Carel and Kidd, 2017). Perceptions of individuals with mental ill health as being dangerous, unreliable, or irrational seem inextricably at odds with widely accepted *epistemic virtues* of honesty, and reliability.[138] These perceptions are not restricted to only one particular kind of psychiatric illness, or diagnostic category. Decreased perceptions of the reliability of individuals with schizophrenia (Angermeyer and Matschinger, 2005; Corrigan et al, 2001), PTSD, and of mental health on a broad scale (Wahl, 1999; Guidry-Grimes, 2015) are well documented, to name only a few. Being invited to participate in research as an expert in one’s own circumstance whilst simultaneously being open about having received a psychiatric diagnosis, then, may well render much of what an ‘expert by experience’ has to say, vulnerable to scepticism or dismissal.

In fact, the very concept of epistemic injustice seems to have afforded some relief to those who have been treated by the psychiatric system, as one service user who now takes part in coproduction explains:

> ‘I stumbled across the concept of epistemic injustice on Twitter… It helped me to make sense of my experiences of harm within psychotherapy and mental health services. I realised I was taught to dismiss my own knowledge and this had deeply affected my trust in myself and my confidence in what I know. From being disbelieved about my experiences to being told I should ignore what my body and mind were telling me… epistemic injustice was everywhere… I have lost count of how many times I have told someone something about my mental health, only for them to turn to the “experts” to confirm what I have said, as if I am an unreliable narrator of my own mind. What often happens is that service-user knowledge is only trusted if it is backed up by a researcher or professional.’
>
> (Coproduction Collective, 2023)

---

[138] For more on reliability and honesty as epistemic virtues, see, for example: Greco, (2010); Goldman, (1999); Lycan, (1988); Sosa, (2007); Zagzebski, (1996).

Just as individuals have spoken of relief at realising there are established conceptual frameworks that make sense of their experiences in other areas[139], the notion of epistemic injustice can be a useful tool for experts by experience to understand how and why their testimony has failed to gain the uptake intended.

I've focused here mainly on the testimonial 'kind' of epistemic injustice that experts by experience face, as this has received the most attention, and seems most apt for current discussions. What I think interesting about the application of epistemic injustice to cases where expert by experience testimony is excluded or afforded less credibility in co-production approaches to mental health research, is that the very reason individuals with lived experience are invited to participate in these spaces is *because of* their direct, first-hand acquaintance with mental ill health. This is not to say that the transposition of negative identity prejudices to the research context is all that surprising –we often allow biases to affect our epistemic conduct, even when we have strong intentions to the contrary– but rather, dismissal of expert by experience testimony, in a research endeavour designed to include such testimony, seems to be a particular instance of what Fricker calls 'ethically bad affective investments' (2007: 35).

In the domain of public mental health, the goal of coproduction is not always to assess legitimacy or efficacy of existent approaches to psychiatric recovery, or service design, but often to understand the etiological, psychopharmacological, or even socially driven bases of mental ill health. A holistic research picture, which is the aim of co-production, must take on board perspectives of those with experience and with lived-insight. This makes the negative identity prejudices which carry over to the research context seem that much more pernicious, and instances of bad epistemic practice on the part of those deflating the credibility of experts by experience. Service users, carers, and those who have been subject to psychiatric treatment are known to have had, or perhaps to still have, direct acquaintance with mental ill health. Dismissal of their accounts as inconvenient, as illegitimate, or as unduly unreliable seems contra to go against the entire motivations for conducting this kind of research. I'll discuss this in more detail in §3 the ways in which expert by experience testimony routinely fails to enter into our shared pools of knowledge.

Fricker's view, then, gives us one way of making sense what's happening in such cases. Negative and prejudicial attitudes to mental ill health affect the heuristics upon which we all

---

[139] For instance, the concepts of neurodiversity (Grandin, 2013); gaslighting (Stern, 2007), imposter syndrome (Feenstra, et al., 2020) and heteronormativity (Butler, 1990) have also been discussed as comfort-giving for those in minoritised groups as a way of making sense of one's experiences.

rely in judgement making. In the context of coproduction, those experts by experience who have been open about their illness or diagnosis, despite having been invited to participate in research based on their own lived experience of that illness or diagnosis, routinely find that their words do not get the right sort of uptake to shift norms, or to affect research conversations. The focus upon the ways in which social injustices lead to epistemic injustices captures nicely many of the facets of the discrimination faced in relation to mental health. What I think, and what I'll go on to say (in section §4), is that understanding the exclusion of expert by experience testimony or knowledge, only gets us a narrow understanding of the picture. On Fricker's view, I, as an epistemic agent in my own right, am responsible for negative identity prejudices that I hold, and the effects that these prejudicial beliefs have on the credibility assignments that I make. I can either rely on the faulty heuristic aids I possess, and give short shrift to evidence of those I take to be members of particular categories on that basis. Or, I can accept counter-evidence, and revise the beliefs I hold, attempting to assign due weight to testimony of my interlocutors, and strive to be epistemically just in my interactions. This is a perfectly plausible way of making sense of how, in individual interactions, expert by experience testimony is subject to deflationary credibility assessments, or is perhaps otherwise subverted. But, in the research environment, we are not only focusing upon individual interactions, and as such, the adage "it's not about me" becomes relevant. The academic or clinical experts here have, presumably, committed to undertaking a coproduced research project. We might expect that this means not all members of the research team hold negative identity prejudices toward those they plan to partner with, or at least that not all of the academic and/or clinical research team are making such ethically bad affective investments, repeatedly. To cast such an aspersion would be to assume that such research projects are undertaken in bad faith. And I don't think that's what's going on in these sorts of pictures. In order that research be done effectively, and achieve any kind of advancement in what we take ourselves to understand, or to do, there are norms, conventions, and broader requirements at play such that knowledge gains uptake, and enters into shared understanding. It is not just what I *qua* epistemic agent, do, but in order to advance knowledge, I must be able to affect a system level shift, or, at the very least, have my research findings enter into shared epistemic resources. Fricker's view may well accommodate this, as a series of repeated instances of credibility deficit assignment which undermine the legitimacy of knowledge offered up by experts by experience. But, in what follows, I'm going to say that making sense of the exclusion of experts by experience using an alternative framework of epistemic harm might help us to understand what's happening in these cases at a system level.

§3. The tensions at play: failures of uptake

Prior to providing an alternative analysis of epistemic harm, it may be helpful to understand a little more about the tensions that are manifest in the research process. Understanding these instances, at the level of individual interaction as epistemic injustice is as I've indicated, I think, a correct appraisal. What I'm going to go on to say, though, is that we can similarly make sense of these sorts of exclusionary research practices at a broader systemic level by understanding them as *epistemic oppression.* The latter concept, I'll say in §4, allows us to understand why coproduction as an approach to research is rife with epistemic harms. But on either view, understanding the ways in which testimony fails to gain uptake or to be received as legitimate knowledge helps to paint a fuller picture of the phenomenon this paper attempts to make sense of.

(i) Testimony received as anecdote

First, there is a purported tension between what is deemed 'hard-science', that is, – evidence based and deriving from medical professionals– and anecdotal contributions to knowledge. Coproduction, as a methodology which does not require those with lived experience to possess the same academic or clinical expertise as the research team *qua* accepted experts, is often seen as an 'additional' dimension of knowledge, bolted on to research projects rather than integral to them. Being invited to participate in research on the basis of your lived, experiential (and sometimes phenomenological) insights, is often received as being invited to speak about those experiences. But experiences and recounting of thoughts and feelings on a personal level are not afforded the same level of scientific credence as the results of a pharmacological trial, or a population level ethnographic study (Rose and Kalathil, 2019; Johnson and Martínez Guzmán, 2013). In fact, as Diana Rose and Jayasree Kalathil recount, in their article 'Power, Privilege and Knowledge: The Untenable Promise of Co-production in Mental "Health"'(2019) often, individuals with lived experience are invited to speak in the very spaces in which their 'illnesses' or 'disorders' are discussed in derogating or distressing terms by more typical academic researchers only moments later. This, they go on to say, is akin to being a subaltern in the research team, and to having one's knowledge rendered unspeakable (2019).[140] Even if you are sympathetic to the value of experiential knowledge, and would agree that instances like those Rose and Kalathil describe are harmful and ought not to constitute the way research is done, you may also agree that present research hierarchies tend to privilege the quantitative or the 'evidence-based', as opposed to the qualitative or narrative kinds of knowledge (Crichton, Carel, and Kidd, 2017). 'Lay' research members (those who are often invited on the basis of their lived experience) are simply not afforded the power or control of research that would allow them to influence research's direction, or to challenge chosen methodologies such that their contributions 'count' in meaningful ways (Slade et al, 2010). Methods that are viewed as value-free, objective, remain privileged over and above subjective or first-hand accounts of distress or service use (Faulkner, 2017). Knowledge that is not deemed objective, and is thus value-rich, or rooted in experience, is, understood in a Foucauldian sense, 'subjugated' (Foucault, 1980; Brown and Strega, 2005: 11). The tendency to prefer 'hard' evidence over 'soft' then, and the additional habit of categorising expert by experience testimony as the latter, predisposes the content of such testimony to dismissal or distortion.

The harm, here, derives from experts by experience being recruited to such projects under the guise of equitable and significant involvement. Coproduction is designed for that very purpose.[141] By inviting an individual with lived experience to participate in research based on their first-hand acquaintance with mental ill health, there is a (not unreasonable) expectation that their contributions will be valued. Accordingly, testimony relating to experience the status of 'other' or second-class knowledge seems particularly harmful, as this testimony forms the very basis for the involvement of such individuals.[142]

(ii) Subversion of message – psychiatrisation or lacunas in understanding

Second, there is a tendency of clinical or professional members of the research team to, intentionally or otherwise, water down, or otherwise subvert or pathologise the contributions

---

[140] Spivak's (1988) notable 'Can the subaltern speak?' outlines the ways in which one's voice can become subjugated in ways which renders speech incapable of gaining uptake.

[141] Tracing the histories of coproduction, and the multitude of definitions of the concept highlight the onus that is placed upon equal and fair participation.

[142] This point might be viewed as contentious by those currently undertaking research given the onus that higher education institutions, research funders, and public sector bodies place on coproducing knowledge. It's plausible that academic and clinical research teams are strongly opposed to recruiting experts by experience but must do so in order to secure funding to undertake their project. However, to then see the testimony of experts by experience as almost a sub-class of knowledge, remains harmful, if that is not clearly communicated to those recruited.

of those with lived experience. This may (as we'll see later in section §4) relate more to do with ingrained societal (mis)conceptions relating to the epistemic virtues, vices, and traits of those with mental ill health.

Typically, this may take the form of the individual with lived experience asserting '*S'* in discussions, but the clinical or academic research partners on the project interpreting this as '*S*'*. Power dynamics carried over to the research environment often mean that experiential knowledge is offered up by those with lived experience but is ultimately defined by the 'experts' in the room. This in many ways unsurprising, when we consider the power which psychiatric professions have to determine the rights, or removal of rights (in some cases) of their patients. Residual and engrained power dynamics transferring from the clinical setting over to the research setting may well affect which testimonies are assigned credibility, and conversely, which are not. Whomever is responsible for the writing up of meetings, or of research progression, or evidence-gathering aspects of the research process, may find themselves reading into an individual's testimony a meaning that simply is not, or was not that. And whilst this interpreting of testimony is in itself a harm, what compounds this particular harm is the way in which such testimony is routinely sanitised or made to fit dominant societal conceptions of mental ill health (Jones and Kelly, 2015). For instance, someone with lived experience might say that they 'value the community which they have gathered around them during periods of ill health' but this could, understood through the lens of psychiatric practice, be interpreted as 'patient is unmotivated to stay well due to the care and attention they receive when less able to go about their day-to-day activities'. Such a subversion of meaning *could* be due to the habits of psychiatric practitioners in interpreting what patients say to them. This is often based upon habitual practices (not dissimilar to Fricker's heuristic aids mentioned earlier) whereby shortcuts are taken based upon experience: often patients demonstrate trait *T* and this could be an instance of *T*, despite the content of the utterance literally meaning *S*. Alternatively, this subversion could be due to a failure of shared frames of reference possessed by expert by experience and clinician.

As Luvell Anderson (2017) notes, often –and particularly when marginalised individuals or identities are at play– some conceptual resources simply aren't shared. Two conversational parties may believe they are talking along the same lines, but the more privileged party makes sense of what they hear based upon their understanding of the world. If this understanding doesn't quite track the understanding that the original speaker had, the end result can be that both feel as though they understand and have been understood one another, however a gap in hermeneutic horizons leads to a lacuna in meaning or sense making (Anderson, 2017).

Simply put: neither party can articulate or take away from an utterance something which they don't relate to. If a clinician or academic has not had the positive experience of finding oneself understood by a particular community in ways which differ (positively) from routine social interactions, that may not be the sense that they take from the above statement. However, they may feel as though they have understood, through the lens of patient interactions previously had, and the expert by experience may have no reason to suppose that their words will take on a new meaning. And it is not only the words we say, and the way they are received that can affect the experience of co-production for those with first-hand acquaintance of mental ill health. Bee et al (2015) express a similar kind of hermeneutic gap as being the cause of many failures in service user-involvement, stating that:

> "service user involvement fails because the patients' frame of reference diverges from that of providers. Service users and carers attributed highest value to the relational aspects but … planning is typically operationalised as a series of practice-based activities compliant with auditor standards" (p.104)

Here, the hermeneutic gap relates to the most valued elements, either of a service, or of the research process itself. Where the focus of academic or clinical experts is procedural, service-users involved can experience exclusion and disempowerment (Carr, 2016).

Further, individuals whose first-hand experience of psychiatric systems, or of forms of marginalisation in the social sense, which are not shared by clinical or academic research partners, may be viewed as hostile, or overly-critical of psychiatry as a branch of medicine. Mad Studies, and the anti-psychiatry movement, have gained a wealth of traction since the 1970s/80s and whilst criticisms of psychiatric practices are by no means restricted to these movements, they are dominant within them. Should an individual with lived experience report their believed illegitimacy of, say, psychiatric diagnosis, in a research endeavour designed to interrogate the use of control and restraint in psychiatric inpatient settings, and the testimony of 'lay' researchers be overwhelmingly negative (as might be expectable), this could be sanitised, or subject to reinterpretation or subversion. The perceived hostility of those with lived experience – in that their testimony challenges accepted practices and standards – might lead to that testimony being omitted, altered or otherwise changed (Hodge, 2005; Lewis, 2014).

Ultimately, what *can* be expressed is often determined by those in more traditional positions of power. The 'rules of research', as Marian Barnes (2002) notes have not been transformed thus far and these rules "define both the way in which deliberation is conducted and who is considered to be legitimate participants in the process" (2002: 329). Thus, traditional researchers retain the power to determine whose knowledge makes it into shared spaces, and what narratives might be able to influence dominant understandings of research processes.

(iii) Duality of roles – legitimate knower, or mentally ill and lacking credence?

Thirdly, there is a duality of role that those with lived experience are required to traverse, often simultaneously. As Rose and Kalathil (2019) note, being positioned as an expert on the basis of one's lived experience in many ways renders one's legitimacy unstable and subject to variance on the basis of perceived mental state. As an individual with lived experience, whose lived experience is widely known in the research team, any expression of emotion or distress can serve to make one appear irrational, unwell, or unstable. And, of course, this has the effect of undermining the legitimacy of the knowledge conveyed in the same way that being perceived as mentally unwell affects the credibility or reliability you may be presumed to have, in social and political spaces. Whilst the inviolability of professional knowledge is a given, or is received as a given, what degree of credibility the testimony or knowledge contributed by an individual with lived experience depends upon the presentation of that testimony or knowledge. Becoming distressed, angry, or even appearing less animated than at previous meetings, can result in the credibility your testimony is assigned being lowered, as there is an inverse (presumed) relationship between credence and legitimacy, and heightened emotional states. This can also lead to what Liegghio calls 'psychiatrization' (Liegghio, 2013), where, like testimony subversion I outlined in (ii) above, what an expert by experience *says* is attributed to, or presumed to be affected by their mental (ill) health. Heightened emotional states, or clinical assessment of the rationality or sanity of experts by experience can lead to either them, or their testimony being pathologised.

Again, this can be – almost equally – attributed to societal attitudes to mental ill health, and to the requirement for rationality in empirical science. Neither party views mental ill health as compatible with our 'norms' of epistemically virtuous practice. Mental ill health is viewed as in tension with rationality almost universally, and whilst it is not the goal of this paper to unpack such a tension, it is something which will be returned to in following discussion.

§4. Understanding epistemic harm as epistemic oppression

What the above scenario illustrates, is a variety of ways in which the knowledge of experts by experience is simultaneously (mis)understood and undermined: either as not scientific enough, as a veiled disclosure of symptoms, or else as being lacking in authority or scientific legitimacy. These can all be explained in various ways, with various causes or reasons pointed to, as the preceding section has shown. Whilst all of this can be explained at the level of individual interaction, I'll now move to more of a system-level view of epistemic harm, appealing to Kristie Dotson's framework of *epistemic oppression* (2014).[143]

§4.1. Epistemic oppression: resilient systems

Dotson defines epistemic oppression as being: 'a persistent and unwarranted infringement on the ability to utilize persuasively shared epistemic resources that hinder one's contribution to knowledge production' (2014: p.116). Akin to the harm done to Fricker's epistemic agent in her capacity as a knower, an individual facing epistemic oppression's epistemic agency is undermined. However, Dotson's view specifically expands beyond the level of individual interaction and focuses upon the ability of an individual *qua* epistemic agent, to draw upon, contribute to, and shift, shared epistemic resources (Dotson, 2014: p.115). Whilst she acknowledges that (like instances of epistemic injustice) there are often social and political factors which undermine or impede the ability of an agent to make use of such epistemic resources, what differentiates Dotson's view from Fricker's, is an account of third-order epistemic oppression. The central claim of Dotson's account of third-order epistemic oppression is that this kind of epistemic oppression is not wholly reducible to social and political factors, but 'follows from a feature of epistemological systems themselves… epistemological resilience' (2014: p.116).

---

[143] There is potential, depending on one's views regarding egalitarian distribution of goods – including knowledge, and perhaps credibility, which would argue that *distributive epistemic injustice* would be an equally appropriate framework to apply given the unjust imbalances in power and privilege which I'll go on to discuss in section 4. I'm sympathetic to this argument, though think there are real reasons to avoid categorising knowledge, or credibility – in this particular context – as something which experts by experience lack. For more on distributive epistemic injustice, see for example: Coady (2017) and Nikolaidis (2021). Relatedly, Dotson's concept of *contributory injustice* (Dotson, 2012; Miller Tate, 2018) could be appealed to, as a means of explaining how testimony subversions occur. Again, I think there's merit in this argument in some senses, but I do not think contributory injustice applies here: experts by experience do not lack concepts that the dominant majority share, nor have they developed resources to explain their own experiences. Rather, the problems here lie in the ways that the knowledge fails to enter into shared epistemic resources because of our epistemological systems norms of research, and our social misconceptions regarding mental ill health. I'm grateful to Paul Giladi for pressing me on these points.

Epistemological systems are, broadly speaking, systems which contain all of our epistemic habits, norms, attitudinal beliefs. They also, following Taylor (2004) and Medina (2011) contain operative and instituted social imaginaries. Social imaginaries can be understood as shared, collective understandings of what normal, and desirable, ways of living are. In the United Kingdom, our attitude to free healthcare as underpinned by equality of access, and the belief that one of the duties of the state is to provide public services, might be considered a social imaginary. They also help us to share common understandings of frequent dichotomies: acceptable/unacceptable beliefs or ways of living, normality and deviance, values and undesirable traits. Operative social imaginaries are those which tacitly govern our understandings and assumptions, influencing our perceptions and behaviour without us ever necessarily becoming aware of their presence. By contrast, an instituted social imaginary is more of an explicit, regulatory framework such as a legal Act, an agreed terms of reference, or other codified behavioural schema; an instituted social imaginary may govern our actions and behaviour in much the same way as operative imaginaries, but we are much more cognisant of the latter (Taylor, 2004). Both operative and instituted social imaginaries partly comprise our epistemological systems. These systems, taken as a whole, affect what promotes or conversely what detracts from, knowledge production (Dotson, 2014: p.121). Whilst epistemological systems are by no means fixed or immutable, uncovering flaws in the system which governs your worldview of knowledge is a sort of meta-epistemic challenge. As such, revisions of entire epistemological systems are difficult to bring about. Dotson describes this as ‘experiencing the impossible as possible and, correspondingly, viewing the limit of one’s epistemological systems that designate the possible as impossible’ (2014: p.132) Bartunek and Moch similarly describe the incredulity one experiences when encountering the limits or drawbacks of one’s own epistemological governance as being somewhat ‘mystical’ (1994: p.28). And given the challenges associated with even identifying the limits of one’s own epistemology, let alone the degree of paradigm shift required to remediate or redress injustices which are baked into that system, or perhaps the imaginaries which it contains, our epistemological systems are highly resilient. Resilience, in this sense, relates to the degree of counter information which can be absorbed into the system itself, without requiring a revision of the resources the system is comprised of (Dotson, 2014). Prudent epistemic practice, according to Medina, requires that ‘epistemic friction’ –the counter-evidence mentioned above– be sought out frequently, such that epistemological systems be updated as alternatives appear and are established as credible (Medina, 2011: p.29). Yet, when the counter-evidence is such that it threatens to topple a well-established hierarchical view of knowledge, the tendency to dismiss or ignore the counter evidence, however credible it may appear, can obscure the limits of the system, and be absorbed as anomalous.

Third-order epistemic oppression, then, occurs when an individual –either due to their social or institutional position, or to social and political factors which undermine their credibility– is unable to create sufficient 'epistemic friction' within the epistemological system that research takes place within (Dotson, 2014). This friction would arise, should they be able to gain uptake, because of the incompatibility of their offered testimony with the system itself. However, possessing neither the power, nor the epistemic virtues recognised by the system within which knowledge production is taking place, to gain uptake sufficient to make visible the limits of the dominant operative imaginary renders their knowledge incapable of entering in to the shared epistemic resources. We can thus present a range of reasons which might lead to the dismissal of testimony. Epistemic oppression, I'll explain below, occurs when (a) and either (b) or (c) apply:

(a) The position the utterer occupies is marginalised either socially, or in a domain specific context such that their contributions are routinely met with suspicion;
and either
(b) The content of an individual utterance is at odds with commonly held beliefs, or challenges norms of epistemic practice, supported by the epistemological system
Or;
(c) Incorporating the content of the utterance into the epistemological system would render the system unstable.

If both (b) and (c) are the case, then, due to the revisions which would be required should the testimony be received as knowledge, it will likely be explained away. Instances of (a) and (b), or (a) and (c), will likely ensure that the individual contribution is delegitimised, or otherwise viewed as irrelevant, misguided, or lacking in credibility. These latter scenarios relate not just to the marginalised position the individual holds as rooted solely in social and political system inequalities, but to the lack of power these individuals are perceived to possess in relation to the shifting of content of epistemological systems. I maintain that structural positionality and power are essential features of epistemic oppression, which is why (a) must be satisfied. The reasons I have stipulated that at least two of the three criteria must apply relates to what I term a 'threshold for epistemic oppression'. To evidence why this threshold requires at least two of the three listed criteria, consider the following scenario.

Taking (a) alone just gets us to an understanding of epistemic injustice, in Fricker's sense, based upon negative identity prejudices. If only (b) as a reason for dismissal of one's testimony were constitutive of epistemic oppression, then any belief or disagreement with a majority view might be considered an infringement upon your capacity as an epistemic agent. Maintaining the stability of the epistemological system as a reason for dismissal or taking some evidence less seriously alone, as in (c) doesn't necessarily constitute oppression either; the contents of such information, or who is providing it, would be required such that (c) be relevant. This is not to say, of course, that routinely reasons like (c) suffice to disregard evidence; on the contrary, I think many of us have dismissed something that doesn't 'fit' with all else we know to be true, or that we value. As Dotson explains, epistemological systems can withstand a great deal of disruption. In actuality, I think it likely that all three of the above criteria will likely be present in most all cases of epistemic oppression. Epistemic oppression then, occurs when information that you have, because of some fact about who you are, and the shifts to dominant epistemic resources that would be required if you were taken seriously (either due to their unsuitability in practice, or to the content of your utterance being at odds with what is commonly accepted) fails to enter into, or bring about a shift in the epistemological system.

What makes this a distinctly epistemic kind of harm lies in what is required to redress the oppressive practice. As we're thinking at a system level, epistemic vices, virtues and habits are all in play, and the norms we rely upon (which kinds of knowledge are privileged), the authorities we recognise as epistemically superior (whose knowledge is privileged), and the barriers to expanding our conceptions of good epistemic practice (what counts as good knowledge) can all be understood in distinctly epistemic terms. An individual might be marginalised based on socio-political inequalities, and this may drive the misperceptions that affect the knowledge of that specific person entering into the collective domain, but the epistemic features of the epistemological system are such that challenging one's own (mis)perceptions would not suffice to redress system level epistemic oppression: our entire epistemological system would require revision.

§4.2. Failure of design? Applying the framework of epistemic oppression to co-production

Thus far then, I've explained what third-order epistemic oppression is, and given some illustration of the sorts of scenarios in which testimony might be subject to epistemic oppression –by requiring a shift or revision of epistemological systems, which an individual operating within the system is unable to bring about. What I've yet to explain, is why the exclusion of experts by experience is especially well understood using this framework. What, for instance, makes our epistemological systems resistant to revision based on the testimony of individuals with lived experience of mental ill health? To begin let's remind ourselves of the three ways I have outlined where testimony is dismissed or accorded less credibility: (i) testimony received as anecdote; (ii) subversion of message by those more powerful in the research context, and; (iii) duality of roles.

In discussions of (i) I outlined the tensions between 'hard–' and 'soft–' science or evidence. Hard evidence is considered more robust, arising from the positivist mode of social research where fact takes precedent over value, and quests for knowledge focus upon that which is 'invariable' and 'universal' (Durkheim, 1982). As Vaditya outlines: 'Qualities such as rationality, reason, objectivity, and impartiality are privileged over, and opposed to, irrationality, emotion, subjectivity and partiality' (Vaditya, 2018: p.274). Alternative forms of knowledge, such as those from the perspectives of marginalised people were squeezed out of common accepted research practice during the growth of positivist modes of advancing knowledge (Kovach, 2005). As such, the academe, as the respected source of knowledge advancement also tends to privilege fact and objectivity, over and above opinion or values-led hypotheses. Our epistemological systems, and our operative social imaginaries, then, are established such that they preference and uphold specific ways of doing research, or arriving at new or expanded knowledge. And these constraints mean that testimony received as anecdote, such as first-hand accounts of distress, simply aren't afforded the status of 'knowledge' (Faulkner, 2017).

Consider also the ways in which Vaditya (2018) has characterised the qualities privileged in the research environment and how these map on to our social conceptions of mental health, or conversely mental wellness. The epistemically more virtuous qualities of rationality, reason, objectivity and impartiality not only indicate robustness in research, but good epistemic practices. Coincidentally, these also happen to be the very qualities presumed lacking if you happen to have lived experience of mental ill health. The negatively valenced qualities Vaidtya highlights of 'irrationality, emotion, subjectivity' (2018: p.274) are precisely those which are presumed inextricably linked to mental ill health. It just so happens, that according to dominant epistemologies, they also make for bad science and less than desirable epistemic practices. Being an expert by experience then, appears to bestow upon an individual in what Townley describes as: "an epistemically disadvantageous social identity, akin to being given a version of the curse of Cassandra" (Townley, 2003: pp.105-106).

Townley is of course, not talking about research into mental ill health. But whilst in Greek mythology Apollo bestowed Cassandra with the prophetic ability to foresee the future, but simultaneously cursed her such that no one would ever believe her testimony (Townley, 2003), in cases of coproduction, the phenomena at play is much less mystical. Rather, experts by experience are invited to participate in coproduction because of their insights, but routinely have those insights fail to enter into the collective epistemic domain of knowledge, as that knowledge, and their very identity, fail to meet the positivist requirements of good science. This could be understood as an illustration of (a) or (b) as above, or perhaps some combination of the two. The content of testimony may be dismissed because of perceived inadequacies in the robustness of the evidence it contains because the expert by experience is not an academic or clinician themselves; lay persons cannot offer up hard scientific evidence, and testimony may be deemed too subjective. It could also be dismissed due to the perceived relationship between mental ill health and the epistemic virtues that the dominant epistemological system recognises as authoritative; irrational individuals cannot offer up rational evidence, as it were. Or, it could be that the content of expert by experience testimony is viewed, against the contents of the epistemological system as being incompatible with accepted views and norms (in the case of anti-psychiatry, Mad studies, or other views which either disagree with, or argue against curative interventions). Any of these scenarios would vastly affect when, and to what degree, expert by experience testimony gains uptake. I suspect it does not happen often.

In the rare circumstance where expert by experience testimony is perhaps received as truthful, and reliable (though still anecdotal to a degree) but is deemed at odds with the existing and widely utilised epistemological system, it likely will still fail to gain the uptake required to act as a catalyst for revision of the shared epistemic resources into which she attempts to have her knowledge enter (Dotson, 2014: p.130). And this again, can be attributed by the extreme resilience dominant epistemological systems display, particularly when it comes to histories of social oppression, marginalisation and injustice. Mental health, and psychiatric illness, have been subjugated categories in Westernised cultures throughout history, and thus anti-psychiatry or Mad Pride type views cannot be assimilated into the epistemological system, without the resultant need to examine our entire worldview of mental health. The more ingrained into culture, institutions and social understandings a view becomes, the more difficult it can be to challenge. Similarly, our research paradigms, funding processes, evaluative mechanisms, and the economy of academic education, which serve to further the successes of those who produce knowledge in accordance with the epistemic virtues and rules of the governing epistemological system, mean that conceptions of research are also entrenched (Vaditya, 2018). By taking this system-level appraisal of the harm perpetuated by coproduction when experts by experience are excluded in research paradigms, and by understanding it as a kind of epistemic oppression, we're able to lay out this systemic injustice. Given the incompatibility, if my arguments here are accepted, of variance in understandings about mental ill health with our dominant epistemologies, it is unsurprising that coproduction has received criticism for dismissing the very knowledge it seeks out.

Thinking about the ways testimony is subverted, watered down, or misunderstood, as in (ii), we might also make sense of this phenomena using Dotson's view. In her paper 'Conceptualizing Epistemic Oppression', she recreates the *Allegory* crafting an image of a row of fettered persons, facing to the left, who increase in their position of privilege from left to right. The furthest left individual is the only person able to see the remainder of the open cave, yet is also the most marginalised in terms of social position (Doston, 2014: p.130). She has a unique position. When she attempts to share knowledge, using dominant epistemic resources she shares with others, e.g., language, conceptual frameworks and so on, but which those further to the right have no direct experience of, she is met with ridicule. She occupies the most marginalised position in the cave hierarchy of power (Dotson, 2014: p.130). Now her assertions may be met with mere disbelief, and those to the right of her might determine she does not occupy a social position commensurate with enough authority to enter knowledge (uncorroborated by more superior individuals) into the collective epistemic resources. Or, as I think more likely in practice, it's possible that those to the right of her attempt to make sense of what she says, based on their own experiences –their hermeneutic horizons. In either case, the content of testimony is changed, or determined by others as lacking in credibility. And this is in addition to, or is perhaps compounded by, those features of the epistemological system outlined when discussing (i) which we might say are the basis for our expert by experience being situated in the position of greatest marginalisation. Similar arguments could be given for (iii). Positionality, as a non-expert research team member with expertise understood in terms of positivist qualities either exemplified by research methods or outputs, or by the individuals undertaking said research will affect what an expert by experience is able to have taken seriously. The degree to which the knowledge she tries to share would create epistemic friction within the epistemological system, will also determine whether she is able enter what she knows into the shared epistemological resources. Whilst our conceptions of science, of research, of traditional ways of conducting these things, and our pernicious attitudes toward mental ill health remain integral parts of both the operative and the instituted social imaginaries which govern our epistemic practices, it is easy to paint a pessimistic picture of coproduction.

§5. Concluding remarks: Why appeal to system-level oppression?

Having explained how Dotson's epistemic oppression helps us to understand exclusionary practice in research, we might begin to question what this view offers, over and above identity-based prejudice. Both pictures provide a plausible account of the sorts of factors affecting which individuals are deemed capable of knowing, and how that knowledge translates (or doesn't) to collective understanding.

On my view, Dotson's account doesn't necessarily explain what's at play more effectively, but it does help to capture two important nuances. First, as a system-based framework, epistemic oppression helps us to understand how knowledge is precluded from entering collective resources even in incredibly well-intentioned research environments. Individual researchers might be amenable to altering their research practices, and may be sympathetic to views which would require significant shifts in epistemological systems that are dominant. But those individuals are too working within the same framework of epistemological systems, and in order that their research be taken seriously, and their outcomes be delivered in accordance with the terms of their funding, they cannot reinterpret or shift the system alone, nor can they step outside of the dominant epistemological system and continue to research. Just as experts by experience face a series of double-binds, so too do the academic and clinical researchers. They also operate within the bounds of epistemological systems insofar as their own cognition and epistemic habits are concerned, and are unlikely to have awareness of the limits of that system when it comes to the incompatibility of mental ill health with virtuous epistemic practice.

Epistemic oppression then, gets us an understanding of an entrenched system of injustice, for which no one individual is culpable, but in which most of us are complicit. We may not even recognise this system as oppressive, and coproduction in particular, as a research methodology designed to empower those with lived-experience as active research partners, may be taken as a quest for epistemic justice, rather than a mode likely to perpetuate harm (Okoroji et. al, 2023; Russo, 2023). And, there are accounts of coproduction done well, where the issues I have laid out here are side-stepped, and experts by experience are able to participate as valued and respected partners (Faulkner et. al, 2019). What this framework 'gets us' is an understanding of prejudices that run deeper than the level of individual interactions or personally held biases. It also goes some way to setting out the enormity of the task ahead, for to truly include individuals with lived experience in research, the epistemological systems governing research and epistemic habits in the academe would require substantial revisions. Coproduction as a methodology is not one which is inherently designed to gatekeep knowledge, quite the opposite in fact. What this paper has demonstrated though, if the arguments I have given are accepted, is that for mental health in particular, changes to research paradigms and social understandings of psychiatric illness are what would bring about change, rather than active participation of the typically research*ed* in existing research culture. Epistemic oppression as an alternative to epistemic injustice, merely helps us to understand how the system is stacked against those with lived experience of mental ill health.

References

Luvell Anderson, 'Hermeneutical Impasses', *Philosophical Topics,* 45(2) (2017) 1–19

Matthias C. Angermeyer and Herbert Matschinger, 'Causal beliefs and attitudes to people with schizophrenia: Trend analysis based on data from two population surveys in Germany.' *The British Journal of Psychiatry*, 186(4) (2005) 331–334

Marian Barnes, 'Bringing difference into deliberation? Disabled people, survivors and local governance', *Policy & politics,* 30(3) (2002) 319–331

Jean M. Bartunek and Michael K. Moch, 'Third-order Organizational Change and the Western Mystical Tradition' *Journal of Organizational Change Management,* 7(1) (1994) 24–41

Penny Bee, Owen Price, John Baker and Karina Lovell, 'Systematic synthesis of barriers and facilitators to service user-led care planning'. *The British Journal of Psychiatry*, 207(2) (2015) 104–114

Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990)

Havi Carel and Ian James Kidd, 'Epistemic injustice in healthcare: a philosophical analysis'. *Medicine, Health Care and Philosophy,* 17(4) (2014) 529–540

Havi Carel, and Ian James Kidd, 'Epistemic injustice and Illness', *Journal of Applied Philosophy,* 34(2) (2016) 172–190

Sarah Carr, *'Position paper: are mainstream mental health services ready to progress transformative co-production? Discussion Paper'*, accessed 21 February 2023: https://eprints.mdx.ac.uk/20267/

Paul Crichton, Havi Carel and Ian James Kidd, 'Epistemic Injustice in Psychiatry', *Psychiatry Bulletin,* 41 (2017) 65–70.

David Coady, 'Epistemic Injustice as Distributive Injustice', in Ian James Kidd, José Medina and Gaile Polhaus Jr (eds.), *The Routledge Handbook of Epistemic Injustice* (Abingdon-on-Thames: Routledge, 2017) 61–68.

CoProduction Collective, *Epistemic injustice and co-production,* accessed 1 May 2023: https://www.coproductioncollective.co.uk/news/epistemic-injustice-and-co-production

Patrick W. Corrigan, L. Philip River, Robert K. Lundin, David L. Penn, D, Kyle Uphoff-Wasowski, John Campion, James Mathisen, Christine Gagnon, Maria Bergman, Hillel Goldstein and Marry Anne Kubiak, 'Three strategies for changing attributions about severe mental illness', *Schizophrenia Bulletin*, 27(2) (2001) 187–195

Kristie Dotson, 'A Cautionary Tale: On Limiting Epistemic Oppression', *Frontiers: A Journal of Women Studies,* 33(1) (2012) 24–47

Kristie Dotson, 'Conceptualizing Epistemic Oppression', *Social Epistemology* 28(2) (2014) 115–138.

Emile Durkheim, *The Rules of Sociological Method*, translated edition, Steven Lukes (ed.) (New York: The Free Press, 1982)
Alison Faulkner, 'Survivor research and Mad Studies: the role and value of experiential knowledge in mental health research', *Disability Society*, 32 (2017) 500–520

Alison Faulkner, Sarah Carr, Dorothy Gould, Christine Khisa, Trish Hafford-Letchfield, Rachel Cohen, Claudia Megele and Jessica Holley, '"Dignity and Respect": An example of service user leadership and co-production in mental health research', *Health Expectations*. 2021(24) (Suppl. 1) (2019) 10–19

Sanne Feenstra, Christopher T. Begeny, Michelle K. Ryan, Floor A. Rink, Janka I. Stoker and Jennifer Jordan, 'Contextualizing the Impostor "Syndrome"', *Frontiers in Psychology,* 11 (2020) accessed 22 May 2023: https://frontiersin.org/articles/10.3389/fpsyg.2020.575024/full

Miranda Fricker, *Epistemic injustice: power and the ethics of knowing* (New York: Oxford University Press, 2007)

Temple Grandin and Richard Panek, *The Autistic Brain: Thinking Across the* Spectrum, (London: Rider Books, 2014).

John Greco, *Achieving knowledge: A virtue-theoretic account of epistemic normativity,* (Cambridge: Cambridge University Press, 2010).

Alvin Goldman, *Knowledge in a social world*, (Oxford: Oxford University Press, 1999)

Laura Guidry-Grimes, ‘Modelling psychiatric disability’, *Journal of Evaluation in Clinical Practice*, 21 (2015), 490–495

Suzanne Hodge, ‘Participation, discourse and power: A case study in service user involvement’, *Critical Social Policy*, 25(2) (2005), 164–179

Katherine Johnson, and Antar Martínez Guzmán, ‘Rethinking concepts in participatory action research and their potential for social transformation: Post- structuralist informed methodological reflections from LGBT and trans- collective projects’, J*ournal of Community and Applied Social Psychoogy.* 23, (2013), 405–419.

Nev Jones and Timothy Kelly, ‘Inconvenient complications: on the heterogeneities of madness and their relationship to disability,’ in: Helen Spandler, Bob Sapey, and Jill Anderson (eds.) *Madness, Distress and the Politics of Disablement,* (London: Polity Press, 2015), 43–57.

Lydia Lewis, ‘User Involvement in Mental Health Services: A Case of Power Over Discourse’ *Sociological Research Online*, 19(1) (2014) Accessed 1 May 2023: http://www.socresonline.org.uk/19/1/6.html

Maria Liegghio, (2013). ‘A denial of being: Psychiatrization as epistemic violence’, in: Brenda A. LeFrancois, Robert Menzies, and Geoffrey Reaume (eds.), *Mad matters: A critical reader in Canadian Mad Studies* (Toronto: Canadian Scholars’ Press, 2013) 122–129

William, G. Lycan, (*Judgement and justification.* (Cambridge, MA: Cambridge University Press, 1988)

José Medina, ‘The Relevance of Credibility Excess in a Proportional View of Epistemic Injustice: Differential Epistemic Authority and the Social Imaginary’ *Social Epistemology,* 25(1) (2011) 15–35

Alex James Miller Tate, ‘Contributory injustice in psychiatry’ *Journal of Medical Ethics* vol.45 (2019) 97–100
Alexandros C. Nikolaidis, ‘A Third Conception of Epistemic Injustice’, *Studies in Philosophy and Education*, 40 (2021) 381–398

Celestin Okoroji, Tanya Mackay, Dan Robotham, Davino Beckford, and Vanessa Pinfold, (2023) ‘Epistemic injustice and mental health research: A pragmatic approach to working with lived experience expertise’, *Frontiers in Psychiatry*, 14 (eCollection 2023)

Diana Rose and Jayasree Kalathil (2019) ‘Power, Privilege and Knowledge: the Untenable Promise of Co-production in Mental “Health”’, *Frontiers in Sociology*, (4) (2019) Accessed 1 May 2023: https://frontiersin.org/articles/10.3389/fsoc.2019.00057/full

Jasna Russo, ‘Psychiatrization, assertions of epistemic justice, and the question of agency’, *Frontiers in Sociology*, 8 (2023) Accessed 20 April 2023: https://frontiersin.org/articles/10.3389/fsoc.2023.1092298/full

Mike Slade, Victoria Bird, Ruth Chandler, Jo Fox, John Larsen, Jerry Tew, and Mary Leamy ‘The contribution of advisory committees and public involvement to large studies: Case study.' *BMC Health Services Research*, 10:323 (2010) Accessed 19 March 2023: https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-10-323

Ernest Sosa, *A virtue epistemology: Apt belief and reflective knowledge,* (Oxford: Oxford University, 2007)

Gayatri Chakravorty, '*Can the subaltern speak?*, in: Cary Nelson and Lawrence Grossberg (eds.) *Marxism and the Interpretation of Culture* (Illinois: University of Illinois Press, 1988), 271–316.

Robin Stern, *The Gaslight Effect: How to Spot and Survive the Hidden Manipulation Others Use to Control Your Life, (*New York: Broadway Books, 2007)

Charles Taylor, *Modern Social Imaginaries.* (Durham, NC: Duke University Press, 2004).

Cynthia Townley, 'Trust and the Curse of Cassandra (An Exploration of the Value of Trust)', *Philosophy in the Contemporary World*, 10(2) (2003) 105–111

Venkatesh Vaditya, 'Social Domination and Epistemic Marginalisation: towards Methodology of the Oppressed', *Social Epistemology,* 32(4) (2018) 272–285

Otto F. Wahl, 'Mental health consumers' experience of stigma', *Schizophrenia Bulletin*, 25(3) (1999) 467–478

Linda T. Zagzebski, *Virtues of the mind: An inquiry into the nature of virtue and the ethical foundations of knowledge,* (Cambridge: Cambridge University Press, 1996)