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**Delivering Better Psychiatric Care:
The Interlink Between Virtue Ethics, Epistemic
Injustice and Psychiatric Practice**

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Student ID Number: 2319346**

Supervised by Dr Rebekah Humphreys

**Submitted in partial fulfilment for the award of the degree of
Masters of Arts: Philosophy**

**University of Wales Trinity Saint David
2026**

Abstract

Delivery of psychiatric care can be achieved through differing levels in phenomenological understandings of the patient's life-world. What will enable sustainable improvements to service delivery is an approach to care that is informed through virtue ethics. The transformation of care models in psychiatry aims towards a more holistic care approach within the community. It will be argued that such an aim requires clinicians to be better trained in virtue ethics and to use these virtues in their direct work with patients. Different layers within the care process will be outlined through an exploration of why ethical virtues aid psychiatric care, including what phenomenological explorations add to the care process and what are the potential harms and epistemic injustices that such processes help to avoid. This work has three main sections. The first details how virtue ethics can better inform psychiatric care. The second offers a lived experience focus whilst critiquing some of the current diagnostic processes that rely on diagnostic categories, Artificial Intelligence analysis and algorithmic treatments. The third chapter discusses how patients can build trust in their clinicians, including when the latter explore resistances to tentative initial interpretations of the patient's life-world. This work can help clinicians and others involved in the development and delivery of services, to prioritise areas where more resource intensive phenomenological explorations will be required. Such care delivery will achieve cost savings, enable better quality of care, enhance clinical outcomes, make more selective use of digital technologies and help meet the ever-increasing demands for psychiatric care. This dissertation ultimately demonstrates that ethical virtues are

not optional extras but are the very foundation of effective psychiatric care. Their centrality must be recognised and acknowledged in the delivery of efficient and just mental healthcare.

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Chapter 1: Introduction

It is evident that psychiatry is ever more relevant now than ever before; many feel let down by false and empty political promises including promises about their potential in life. Failure to achieve promised goals can lead to feelings of anxiety and distress. Psychiatry aims to restore value to people's lives, serving as a tool that helps ensure justice to those afflicted by mental illness, by helping reduce their distress so as to continue with one's life journey. Current psychiatric services must place greater emphasis on cultivating and applying ethical virtues within care practices. The use of phenomenologically informed care furthermore helps reduce the suffering of those with chronic severe conditions, helping them in their quest for hermeneutical justice. Through careful identification where resources are required to be placed, clinical objectives can continue be achieved.

Psychiatry is an essential element in the care and prevention of mental and behavioural problems. It takes into consideration how societal and relational factors impinge on one's life, particularly when distress causes symptoms that are pathologised into an illness category. Psychiatry also interfaces with genetic and other research that promise to deliver individualised pharmacological and genetically engineered treatments into the future. It adopted the biopsychosocial model of care delivery to fulfil its aims;¹ notwithstanding, the biomedical approach, that relies heavily on neurochemistry, genetics and on one's brain structures, is

¹ George L. Engel. 'The Need for a New Medical Model: A Challenge for Biomedicine.' *Science* 196, (1977): pp 129-136.

often portrayed as being more promising and cost effective. This latter approach, however, underplays the effects of relationships, hardships and trauma on one's experience of life and illness, focusing instead on diagnosis and treatment.

Clinicians are faced with ever increasing demands for care, particularly for children and younger adults. There are many social factors that play into such demands, including the difficulties young people face in achieving their aspirations through limited external resources and supports. This crisis has led to an ever rising increase in rates of pathologised anxiety and low mood; it has also led to many seeking alternative explanations and justifications for their struggles throughout life, seeking to define themselves through such conditions as Personality Disorders and Attention Deficit Hyperactivity Disorders. It is now the time to focus on a more positive approach to care, one that builds on everybody's internal resources through pedagogy and mutual supports. Virtue ethics is such a way that can, at relatively little extra cost to care, offer a partial solution to this predicament.

The biopsychosocial approach facilitates a collaborative partnership between patients and clinicians which the biomedical model cannot support. Such collaborative partnerships allow clinicians to better understand the patient's life narratives, their phenomenological experiences and also allows patients to better map onto the ethical virtues that clinicians hold and exhibit during clinical care. As a practising psychiatrist working with those who experience complex health comorbidities, I take note of how much it matters to patients that they

feel listened to and understood as valued experiencing human beings. Patients hold individual memories and aspirations; they have certain ingrained approaches to life, as informed by their virtues and a life narrative affirmed within their social circle. Being valued as an experiencing individual is what helps patients to recover and to flourish.

Psychiatry is grappling with a number of other challenges including that of the use of algorithmic diagnosis and treatment decisions, as well as Artificial Intelligence led diagnoses and treatments, predisposing patients to the risk of impersonal care. There are managerial pressures to reduce the depth and duration of clinical interactions, as a way to reduce waiting lists. Such pressures result in a loss in personalised connectedness within mental healthcare that can prove to be ethically difficult to uphold, particularly for those practitioners who rely on ethical virtues in their everyday practice. It has contributed to increased rates of mental burnout in mental healthcare staff and to an ever-deepening recruitment crisis.

Within society, mental healthcare is a tool used to afford justice for the mentally ill who need protection and support during care. In fulfilling such duties, psychiatry is exposed to criticism about the limitations to what it achieves. Psychiatric practice has evolved through learning from past errors and continues to change in line with the sometimes less than conclusive current best evidence. Admittedly, psychiatry has contributed to causing injustices such as during institutionalised care; however since many causes of epistemic injustice have strong societal and cultural roots, it often has had to run counter to the norms of society so as to

achieve justice towards patients, as for instance the historic resistance within psychiatry to treating homosexuality through chemical means. The virtuous clinician reflects on care processes during their quest for justice; one factor that supplements ethical virtues in such a pursuit is that of phenomenologically informed care. The dissertation will be critically analysing how virtue ethics can help lead to changes in how society treats those recovering from illness and disability, leading to more supports and less fragmentation in care delivery, following Alasdair MacIntyre's insights.²

In this work, arguments will be presented as to how effective psychiatric care can continue in future, to be provided by clinicians utilising ethical virtues, thence reducing overall risks of epistemic injustice. The use of ethical virtues in psychiatry allows clinicians to engage with their patients through an enhanced understanding of lived experiences, life narratives and self-identities as experienced throughout the illness. Such practices facilitate humane care that then primes society to become more accepting of the experiences and contributions of those suffering from mental illness.

This work will define how virtue ethics, the ethical approach that allows one to develop and practice character traits such as those of justice and wisdom, positively contributes to psychiatric care. Psychiatric phenomenology, the study of the patient's lived through experiences and how illness changes one's sense of self, is outlined and considered as

² Alasdair MacIntyre. *Dependent Rational Animals; Why Human Beings Need the Virtues*. Duckworth, 1999.

being an ethical tool that affords value to a patient's life. Epistemic injustice, the unfair dismissal or undervaluing of another's knowledge and experiences caused by biases linked to power imbalances, is analysed in a nuanced manner in relation to its relevance within psychiatry. In doing so, credit is attributed to psychiatry's role in fighting and advocating for epistemic justice, rather more than other authors have done so far. There will follow an explanation as to how psychiatry can support the development of helpful life narratives, coherent stories that patients make and that they tell themselves so as to render coherence to their experience of life. Such coherence links one's past memories to their future goals through everyday experiential life. Through such narratives one lives their socially validated life.

In the following chapter, philosophical analysis will focus on why interdependencies are required for our mental wellbeing and how these can be made use of in relations of care within psychiatry. Such interdependencies rely on ethical considerations one develops and applies, including through the development of life narratives that allow for the valuing of others whilst one contributes to the common good. In the third chapter there will be presented an exploration of what phenomenological inquiry brings to psychiatry that ties in with virtue ethics. Next, one finds an exploration of factors that help protect against epistemic injustice within mental healthcare. These lead to an outline of a normative six stepped model of care interventions; it is then argued how the model highlights when certain elements of care can justifiably be rationalised. The concluding chapter provides a critical analysis of

findings whilst also discussing the likely impacts that artificial intelligence will have on the provision of future mental healthcare.

Chapter 2: How Ethical Virtues Improve Clinical Care

2.0.0 Introduction

In this chapter, I begin to explore why ethical virtues matter in the delivery of mental healthcare; I start to build on the hypothesis that better training for mental health clinicians in ethical virtues delivers better clinical outcomes. Training can be through modelling from others or through individual and group reflection particularly on case study ethical scenarios, focussing on the use of virtues such as justice, care and compassion as a means to balance ever pressing efficiency demands in the care process. Ethical systems serve as guides for individuals and groups in processes of decision making; virtue ethics prioritises character development so that one becomes a good person whilst enabling both individual and communal flourishing. I hold that character development enables everyone to prepare better for disappointments and illnesses in life; for clinicians, further virtue ethics training enables better care, enhances empathy and facilitates patients to better trust in the care provided.

Increased demands for mental healthcare particularly in young adults have multiple drivers, including the effects of social pressures through social media, existential concerns linked to environmental crises, cost of living pressures and fears around the effects of Artificial Intelligence on future job prospects. Meanwhile, good health has many determinants, signifying that the provision of good healthcare requires a holistic approach whereby social factors are seen as one of the key drivers for

wellbeing. A biomedical focus does not give due weight to social factors and this negatively impacts the delivery of mental healthcare. Virtue ethics can help limit these negative impacts whilst it also helps to focus on how one's kinship's roles enhance the common good. I will particularly critically reflect on Alasdair MacIntyre's insights into how one's dependency needs require acknowledgement through the development of virtues and compare these insights with those of other philosophers, including Shelley Lynn Tremain, who emphasise the negative effects of certain social factors on wellbeing.

2.1.0 Immersion into the Symphony of Relations

2.1.1 Phenomenology, homeostasis and ethics

I begin by outlining how human experiences offer us the possibility for sustained wellbeing. Human experiences such as felt emotions or external sensory stimuli, such as the sense of smell, are primary in the sense given by Maurice Merleau-Ponty.³ Such experiences provide us with the basis for evaluation, thus being able to perceive what is risky and dangerous. In depressive illness however, the condition for instance affects how the passage of time and the proximity to others are perceived, leading to feelings of being distant from others and whereby time seems to have become stuck, so the person is unable to act or to

³ Maurice Merleau-Ponty. 'The Primacy of Perception,' in *The Primacy of Perception and Other Essays on Phenomenological Psychology, the Philosophy of Art, History and Politics*. Edited by James M. Edie. Northwestern University Press, 1964: pg.12. Here Merleau-Ponty, in denying a cogito that interprets, asserts that 'Matter is 'pregnant' with its form, which is to say that in the final analysis every perception takes place within a certain horizon and ultimately in the world.' The final perception takes place within the world; we experience perceptions as we live. Constant perceptual experiences provide a sense of time, a sense of unity of being; thence consciousness is perceptual. Accordingly, I am my body.

seek social interactions with others. In the right conditions and with the right supports, experiences can continue to afford us with the possibility to adjust back to a healthy homeostasis, then continuing to offer us experiences we can treasure and value, emphasise Carlos Lopez-Otin & Guido Kroemer.⁴

Most such experiences involve an element of sharing, based on biological values, whereby one generally cannot continue to survive all on their own.⁵ As social beings, our life is based on relations of dependence; dependence on parents and carers as children, dependence on others for social sharing and intimate relations, as well as dependence on others for care and treatment when ill or disabled. Each one remains vulnerable at all times during our lives. Whilst our biology offers homeostatic mechanisms that help manage impacts, these are not enough for one's continued and flourishing existence, particularly during severe mental illness. What are also required are rules of interactions whose biological origin can be seen to originate in other animals but that build on human biology, as then expanded into Nicomachean moral virtue considerations by Aristotle.⁶

⁴ Carlos Lopez-Otin & Guido Kroemer, 'The missing hallmark of health: psychosocial adaptation'. *Cell Stress*, 2024: pp. 21-55. Here the authors redefine health in a positive fashion, rather than the absence of disease. There were initially eight postulated fundamental biological characteristics for health, including maintenance of homeostasis over time. The authors argue for the addition of 'psychosocial adaptation' to the characteristics; this refers to the tension between the individual and socioeconomic contexts, a conflict that has to be continually resolved by adaptations that optimize one's capacity to cope with frustrations and with the ability to contribute to the collective success of social groups.

⁵ Alasdair MacIntyre. *Dependent Rational Animals*. Duckworth, 1999. In this manuscript, MacIntyre highlights the dependence of human nature whilst appealing to our independent thinking so as to become more concerned about those marginalized through illness, old age and misfortune.

⁶ Anthony Kenny. *The Aristotelian Ethics*, 2nd Ed.. Oxford, 2016. There is ongoing debate about the primacy of Aristotle's major ethics treatises, namely Eudemian and Nicomachean ethics. The former is seen by Kenny as primary and focuses on the role of pleasure and avoidance of pain on moral virtue. The latter is often seen as primary by other Aristotelians and focuses on rational action and reflection. By moral virtue considerations I am here referring to the learnt guiding qualities that help

2.1.2 Biology, vulnerability and social dependence

In an analysis of Charles Darwin's work, Georges Canguilhem concludes that to live is to submit one's individual differences in characteristics and behaviour to the judgement of an ensemble of others.⁷ MacIntyre follows Canguilhem in reframing that survival is a cycle requiring one to subsequently go on to judge others; thence our survival depends on successful social relatedness.⁸ Ongoing threats to homeostasis are broad and far ranging and include threats to basic alimentary needs or to mental wellbeing such as those resultant from toxic childhood upbringing. They also include the effects on one's immune system of chronic stress on the body, predisposing to heart disease, cancers and mental illnesses. Such stress will lead to epigenetic effects on one's genes that will recurrently predispose to further physical and mental ailments.⁹

Humans have successfully dominated the world space when they went beyond communication with each other to a conceptualising of a number of virtues that acknowledged the interdependence on each other. This is whilst humans also acknowledged vulnerabilities that could become

us in our ethical considerations for the good of all. They include compassion, justice, respect, courage, responsibility and kindness.

⁷ Georges Canguilhem. *Knowledge of Life*. Fordham University Press, 2008: pg. 105. Canguilhem previously outlined the difference between life and machines is next elaborating on that we have a broad latitude to act which leads us to different potentialities.

⁸ MacIntyre, *Ibid*. MacIntyre at pg. x claims that he 'was in error in supposing an ethics independent of biology to be possible...no account of the goods, rules or virtues that are definitive to our moral life can be adequate that does not explain- or at least point us towards an explanation – how that form of life is possible for beings who are biologically constituted as we are, by providing us with an account of our development towards and into that form of life.'

⁹ Leonardo Massoni, 'Epigenetic and Mental Diseases: The role of Psychotherapy'. *Int. J. Transl. Med.*, 2024: pp. 450-462. Mental illness is often the result of a genetic predisposition combined with environmental factors. When the DNA's expression changes, this can lead to psychiatric disorders. Stressors during upbringing can thus influence DNA expression in a way that causes mental illness. According to some recent research however, later experiences including those afforded by psychological therapies can modulate positive epigenetic changes in our DNA. This thus provides hope on mitigating the otherwise lifelong effects of traumatic life experiences.

minimised through the implementation of moral ethics. This evolutionary transcendence happened through accumulated experiences over the centuries. Individually, one typically starts to manifest these characteristics from adolescence, as one reflects on their individual experiences. Neurodevelopmental findings such as those by Edouard Claparede, nevertheless indicate that during our lives, one remains at the centre of our milieu, a milieu that only the particular individual organises and structures.¹⁰ In order for the clinician to gain insight into how a patient's world is structured, it is essential for the clinician to obtain and empathise in the first hand with the patient's experiences throughout the whole treatment process. Following Canguilhem, this milieu is the world of the patient's and clinician's perception; pragmatic experience through our actions is therefore;

*orientated and regulated by the values of immanent tendencies, [one] pick[s] out quality bearing objects and situate them in relation to each other and to him. Thus the environment to which he is supposed to react is originally centred on him and by him.*¹¹

2.1.3 Self-identity, consciousness and experience

One's individual experiences characterise their understanding of their body and of the interactions with others. For David Chalmers, conscious experience is the foundation of one's acts.¹² One's self identity is thus

¹⁰ Edouard Claparede. *L'Education Fonctionnelle*. Delachaux & Niestle, 1931. Claparede, a contemporary of Sigmund Freud, amongst other findings recognised that in our actions, we subconsciously take into account our suppressed memories.

¹¹ Canguilhem, *ibid*. Pg. 118.

¹² David Chalmers. *The Conscious Mind*. Oxford University Press, 1996: Pg 292. Chalmers furthermore outlines the creative processes around conscious experience as; '*a realization of an information state; a phenomenal judgement is explained by another realization of the same informational state. And in a sense, postulating a phenomenological aspect on information is all we need to do to make sure those judgements are truly correct; there really is a qualitative aspect to this information,*

formed through experiences in this world, experiences that are both within the body as well as experiences with the social and material world. Such an identity is subjected to continued review, whereby the relations of our experiences are continuously being reinterpreted. Whilst some are affirmed and built upon, others will become less foundational and are therefore pushed back into our memory bank. Meanwhile, our continuity of identity remains under threat throughout our lives from conditions such as those that afflict the mind or those leading to severe bodily disfigurement and disability.

Self-identity is therefore related to one's individual memories and to one's place in the social world. Our memories are subject to change with time but nevertheless, our concept of self is based on reconnecting our past experiences to our current ones. This can be severely affected in mental disorders that impact on how memories are stored and used, such as in dementia. The impact on the mentally ill or disabled self is further compounded by social power relations, as succinctly outlined by Shelley Lynn Tremain;

*the ontology of disability does not exist apart from, nor prior to, relations of power that bring disability into being as that kind of thing...the ontology of disability and indeed the ontological status of disability are mutually constitutive with and reinforce the power relations that circumscribe them.*¹³

showing up directly as phenomenology and not just a system of judgements. So this allows consciousness to cohere very nicely with cognitive structure, leading to a more tightly knot view of the mind'.

¹³ Shelley Lynn Tremain. 'Disaster Ableism, epistemologies of crisis and the mystique of Bioethics' in the *Bloomsbury Guide to Philosophy of Disability*, Ed By Shelley Lynn Tremain. Bloomsbury, 2024: pg. 26. Tremain supports Foucault's conceptions on mental health and the care offered to those so diagnosed; these are now being extended to disability in general. Most mental illness is chronic in nature and also results in longer term disability.

Threats to self-identity can lead to the risk of losing one's self-worth in relation to what they can do for themselves or others. How one relates to others is crucial for their emotional wellbeing. Although the need for good relations is inherently an animal instinct, this instinct gets transcended with our perception of a self that is separate yet dependent of others. A separate self-identity can however become pervaded by doubts in emotional and personality disorders, such that one will be unable to decide for themselves. What ultimately enables adaptive separations is the ability to justify choices one makes, choices that comprises a difference; such an ability relies on factors such as language. Language thereafter helps one to explain and to justify why one prefers to take a certain course of action. The use of constructive language, including the use of logic and rhetoric therefore enables another to point out things that one may have missed to factor in when reaching choices and decisions.

2.1.4 Empathy, language and social interaction

Empathy is the clinician's epistemic tool for understanding how the patient understands the world. It requires mutual interactions on an emotive level, leading to the ability to accurately map the other's emotions onto the perceiver's past experiences. Such mapping can lead to sympathies with how the other is experiencing the world; furthermore, it involves the mapping of our previous experiences with the experiences that the other appears to be currently having. Empathy is a deliberate process similar to the use of language; both processes can lead one to better understand others and to enhance their relationship

with the other. Empathy is then likely to elicit action responses towards the perceived needs of the others. It is through such experiences that one helps protect others who are in distress; such a process is of value as it also helps one appreciate their own vulnerability and the possibility of future support needs. Some philosophers, including Lauren Berlant, consider the virtue of compassion as having shades of egotistical motivation.¹⁴ Whilst on the one hand clinicians need to remain alert to the risk that their compassion does not serve personal narcissistic needs, they also need ensure that patients do not become overly attached to unrealistic hopes around treatments and recovery.

Humans have an understanding of the elaborate social networks around them; this awareness helps them to be self-directed whilst achieving desired goods. Adrian Meier & Leonard Reinecke argue that this awareness is however undermined within social networking services including social media, due to the hidden agendas of those who maintain such systems.¹⁵ Social awareness is otherwise a continuous process akin to memory in that both prepare us to direct our actions, informing our individual judgments of when to act and what to expect as outcomes from an interaction. Individual judgements are informed by past experiences, desires, as well as a dose of realism in the sense that one

¹⁴ Lauren Berlant. 'Introduction. Compassion (and Withholding)', in *Compassion: The Culture and Politics of Emotion*, Ed. by Lauren Berlant. Routledge, 2004: pp.1-14. For Berlant, compassion is not just a virtue but also a political and cultural affect that is linked with economic, social and historical drivers. It can and often does serve as a privilege that helps maintain the distance between the observer and the afflicted.

¹⁵ Adrian Meier & Leonard Reinecke. 'Social Media and Mental Health' in *Emotions in the Digital World*, Ed. by Robin L. Nabi & Jessica Gall Myrick. Oxford University Press, 2023: pp. 215-234. The authors provide an outline of concerns related to the use of social media on mental wellbeing. Social networking services and other digital media have modified how humans maintain and initiate social bonds under the aegis of corporations, governments and others with diverse motives, which raise a host of new ethical questions.

considers the possibility that they do not know all the pertinent relevant factors and that things will not always turn out how they wish them to. There will always be unpredictable happenings and outcomes that are in the realm of luck and chance. One therefore develops a conceptual map of their objectives, as well as an awareness of potential thwarting situations whilst considering counterfactuals, with an outline response for each such situation. Over time, one develops expertise about the effectiveness of their judgements and actions in the world of goods and social relations. Such expertise helps enhance one's self-concept of individuality; however, such personal expertise may be impaired in mental illness, such as in personality and affective disorders.

2.1.5 Social awareness, judgement and narrative

Most of our actions are un-reflective but are nevertheless influenced by suppressed memories; here, one gives little concern as to alternative acts they could perform. Memories of performed acts informs us of the experience of both the event and how others and ourselves reacted to the act. Hence experiences tend to have two elements, the natural event that is encountered and how one perceives the event, based on one's past experiences and social context. MacIntyre perceives that the development of language helps formulate an always evolving inner narrative of how events happen in experience, with sub-narratives that help inform counterfactual situations that one may experience in the future.¹⁶ The process of recovery from mental illness helps in the reauthoring of one's narrative through the actual illness experience.

¹⁶ Alasdair MacIntyre. *Ethics in the Conflicts of Modernity*. Cambridge University Press, 2016. MacIntyre emphasizes on a narrative unity of which the agent is both the subject and author. This

Human narratives are world forming; for Martin Heidegger,¹⁷ one runs an ongoing live commentary of the experienced world, whilst trying to anticipate future goods and risks. One makes their world through their classifications of things, initially through things that are basically good versus things that are bad. One evolves their classifications in the direction of their own peculiar goods and interests. Such a classification of experiences not only allows one to form their world, but also their self-identity and narrative. During health, one is then able to stand back from the experience of their surrounds and imagine factors that they can change to make life less threatening and more pleasurable. One can only pay attention to things that have an impact on their experiences; things that are in the universe but that one cannot experience, remain unknown. Empathy and trust during therapeutic interactions allow patients to enhance the healing experiences, expanding their world through such healing experiences.

External reasons, allow one to pass judgement on their previous judgements and beliefs.¹⁸ Flourishing as a human being requires that one

narrative explains what we are accountable for. We need to be able to explain ourselves, what we plan to do, what we are doing now and what we previously carried out. Such motives for acting that we explain to others will determine our future relationships with others. (pgs.231-232)

¹⁷ Graham Harman. *Heidegger Explained; from phenomenon to thing*. Open Court, 2007: Pg 61.

Harman explains that for Heidegger, Dasein is always being in the world and is inseparable from the world. Being in the world is a unified structure. Being in means that Dasein is immersed in the world, involved with it, permanently intertwined and occupied with it. Only Dasein can touch entities since only Dasein has access to them or is truly aware of them. Dasein is always marked with facticity, always finding itself in a particular situation with highly specific possibilities. For the most part, facticity does not take the form of knowledge; Dasein has to somehow rise over the usual interaction with the world in order to gain anything that resembles knowledge. Language thus not just labels reality but creates it. Language thus can create the world of wellbeing and illnesses, of disability and of truth.

¹⁸ Bernard Williams. 'Internal and External Reasons.' *Moral Luck*. Cambridge University Press, 1981: pp.101-113. Williams explores motivational sets one has developed, including how sometimes such motivational sets are based on error, at other times on false beliefs, and expands on how they have

makes judgements that not only help them as an agent but that also enable others to flourish. One is able to converse, discuss and argue with others about when and how to act. This process can be taught, whereby clinicians can reflect and learn from the experiences of others. One is required to separate their own desires for pleasurable egotistical goals and instead to focus onto other goods, such as social coherence and mutual supports.¹⁹ Through such flourishing, we can reduce risks of epistemic injustices in mental healthcare.

2.2.0 Virtue Ethics in Aid of Mental Healthcare

2.2.1 Practical reasoning, insight and the social context of illness

Mental health disorders can result in behaviours that pose threats to life and that defy rational explanation; for instance, in depressive illness, where one presents with apathy when there would be reasons to act. Such existential threats are nevertheless not necessarily negative argues Friedrich Nietzsche, whereby even a most severe crisis can lead to fresh motivations and other insights about one's experiences in the world.²⁰

to heuristically connect with previous and other motivational sets. Such motivational sets can help one understand himself through deliberative reasoning. One picks up on the moral dilemma of who is responsible to act, particularly when one factors costs of taking a stand and also the fact that many others opt to take a 'free ride'. Williams perceives that we can and do have reasons for rationality that are purely egoistic but concedes that we also can have notions of rationality that are not purely means end, but that those who have purely egoistic motivations are not necessarily irrational in not pursuing non egoistic goals.

¹⁹ Alasdair MacIntyre. *After Virtue*, 3rd. Edition. University of Notre Dame Press, 2007, (pp.264-278). In the postscript to the 2nd edition, MacIntyre expounds on how his account of the virtues proceeds through three stages. The first concerns the virtues as qualities necessary to achieve the goods internal to practices, the second considers them as qualities contributing to the good of a whole life, and the third relates them to the pursuit of a good for human beings the conception of which can only be explained through social practices. Virtue morality has at its core evidence how the qualities of one's character relate to the quality of one's actions, judgements as how rules are to be formulated and so on.

²⁰ Friedrich Nietzsche. *Thus Spake Zarathustra*. Project Gutenberg; <https://www.gutenberg.org>. Nietzsche sees humanity as facing an existential crisis that requires a change in our attitude to life.

Conditions that impair practical reasoning in a mental health crisis, can for instance, lead to impaired motivation to engage in processes of justification or in distancing from obsessive desires. Such conditions are nevertheless often complicated with a lack of insight, a relative inability to perceiving difficulties and disabilities that others can see in a person and that sometimes arise due to mental disorders. In order to imagine future options or opportunities, one needs to retain both a self-image and a self-belief as supported by those in their social group. Elaborating on Michel Foucault's thesis around illness, the condition is not just related to the individual but is a symptom of issues within the individual's group; the group can help reduce the impacts of illness and disability.²¹ With more imagination and supports, disability that results from mental illness can be alleviated through the motivations and insights one gains within a social network that holds onto ethical virtues.

Being motivated to embrace new experiences and to avoid risk and harm is a healthy state requiring that one engages in intellectual reflective exercises, utilising one's learnt virtues. Moral virtues that are habitually utilised become character traits of that individual; these are either learnt from others or are self-taught. Virtues in this sense serve as positive cognitive strategies that can be utilised to challenge negative cognitive mindsets.

We may have to live in a world of power relations but it is up to us on how to manage the manifestations of such powers.

²¹ Michel Foucault. *Society Must be Defended*. Penguin Classics, 1997. Foucault interprets the world of groups of individuals within a culture through power struggles, an ongoing confrontation with knowledge being key in holding such power relations. The individual is thus caught in nets of power relations that control, train, supervise and correct thought and behaviour. Such a line of thinking brings forth doubts about opportunities for the expression of one's internal motivations.

Virtues call for an inner reflection on how to react to threats and opportunities, whilst taking into consideration another's needs. One thus acts according to their own self-identity, in a process that matches what others ascribe to them. This self-identity persists and provides motivation for the courage to face new realities in life. Whilst identity is threatened during mental illness, virtuous clinical care can support the maintenance of a patient's self-identity through incorporating the experiencing of illness into a narrative that continues to provide meaning, as one continues to be valued within their community.

2.2.2 Self-identity, care and clinical relationships

Self-identity provides the confidence that allows one to evaluate their own strengths and weaknesses, so that one can further seek support and guidance. Maintaining a positive self-identity favours eudaimonia and enhances one's personal growth; one is for instance, better able to question and challenge incipient negative cognitions linked to recent life events. Personal growth is facilitated by relationships that offer support and care during episodes of illness; such care can engender significance to one's life, as well as provide hope for one's future. This personal growth furthermore allows one to identify strategies that help build resilience towards future illness relapse. A virtuous clinician remains aware that all interactions during the care episode are at risk of epistemic injustice, whereby symptoms and experiences can fail to be adequately understood by clinicians.²²

²² Miranda Fricker. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford University Press, 2007. Fricker's insights have been used extensively in studies about how to improve mental healthcare. This will be the subject of further analysis in chapter 4.

Social networks that re-affirm one's self-identity will inevitably include others who are also suffering from illness or disability. These individuals also form part of the process of one's affirmation. It is a virtue for one to define themselves through all those around them, inclusive of family, friends, peers and, in the case of patients, clinicians; for the case of clinicians, they also define themselves through their patients. Through such networks, one can affirm their individual morality, whilst protecting it against moral errors. This reflects the importance to remain grounded in one's society; one has to remain of value to others within their networks and therefore to belong rather than just being the provider linked with a particular good, resultant from a particular skill set that one has. As pertinent to all health clinicians, for MacIntyre, developing one's ethical virtues helps to protect oneself and others for whom they care.²³

2.2.3 Clinical virtue, responsibility and practice

For the individual clinician, independent practical reasoning involves training to be ready to better explore and evaluate the judgments of others, then becoming better able to more justly explain another's reasoning. This allows for one to critically review the other's actions, as well as one's own. Such a clinician demonstrates courage whilst having difficult conversations, remaining self-regulated and level headed during stressful disagreements. The clinician furthermore takes on a degree of responsibility for others, including peers and patients, through

²³ Alasdair MacIntyre. *Dependent Rational Animals*. Duckworth, 1999. (pp. 97-98). Here MacIntyre writes that; *Without developing some range of intellectual and moral virtues we cannot first achieve and then continue in the exercise of practical reasoning; and without having developed some range of those same virtues we cannot adequately care for and educate others so that they first achieve and are then sustained in the exercise of practical reasoning...without the virtues, we cannot adequately protect ourselves and each other against neglect, defective sympathies...and malice.*

participation in debates or appraisals of others, debating the other's moral reasoning and the consequences of their actions.

Unconditional care and compassion are ultimately virtues that enable others to flourish. The virtuous clinician gets to feel included, whereby they can significantly contribute to their community. One's self-identity remains grounded as it transcends onto the identity of the community they serve. Such a community one lives in can be seen as a shared resource for all who inhabit it, a place one and all can learn from each other's life experiences. Here, everyone benefits in seeing each other coming to terms with the difficulties that life throws at them.²⁴

Following Thomas Aquinas, *decentia* signifies the minimum reckoning of what is due to others; it grants others their dignity and prompts one to aim for mutual understanding.²⁵ Virtues as used in clinical care are initially for the clinician's own sake, so as to do good whenever nature demands action. Such a practice helps the clinician, patients and others within their sphere of action. By utilising ethical virtues, clinicians will emphasise empathetic understanding, whereby a patient gets to trust that the clinician believes and understands their experiences. Such clinical wisdom then allows care to be specifically tailored to the patient's situation, engendering the building of a longer trusting relationship that promotes healing.

²⁴ MacIntyre, *Ibid.* (pp 155-166).

²⁵ Thomas Aquinas, Summa Theologie. Thesumma.app, <https://www.thesummaapp>. Here, Aquinas asks whether right is the object of justice. He agrees with Celsus that 'right is the art of goodness and equality,' whereby art is a virtue. Justice denotes an equality, a reference of one thing to another. The virtue of justice is thus different to some of the other virtues that mostly benefit the beholder.

2.2.4 Psychiatry and classification

Psychiatry is criticised by Ian Hacking for its self-authenticity, whereby it allows itself to grant new domains of knowledge; this adds a new dimension of challenges facing the virtuous clinician.²⁶ Entity realism about the existence of specific mental disorders as used in international classifications, includes a belief in hypotheses about the aetiology of mental illness. Here, realism remains justifiable only through the clinician's ability to actively intervene, such as through the use of pharmacotherapy and psychotherapy to change the patient's experienced phenomena.

Making up people or dynamic nominalism, alludes to the classification of people that are not simply discoveries of pre-existing kinds; through active processes that interact with the original classification, the process makes up ever more new kinds of people and patients. For Hacking, psychiatry risks creating a looping effect, whereby there exists a dynamic interaction between the classified individuals and the classifications themselves. People are then at risk of changing their behaviour, their own self-concept and their lifestyles in response to being so identified and described. This paves the way for new illnesses, new tests and new treatments, leading to demands to treat conditions that were non-existent even a few decades ago. For Hacking, such social constructivism is a process that the virtuous clinician needs to be wary of, as otherwise they run the risk of medicalising behaviours and distress, mislabelling

²⁶ Ian Hacking. Making Up People. *London Review of Books*, Vol 28, (2006): 161-171. For Hacking, disability and illness are entities produced by social processes rather than nature. The conditions do indeed map onto biological processes but their impacts and classification are socially derived.

conditions as requiring clinical intervention, treatment and labelling where ethical justice demands that none should be required.

2.3.0 Concluding Comments

I have here focused on how mental illness threatens one's self identity. Shared ethical virtues between patients and clinicians allow for trusting relationships that help improve clinical engagement and care compliance. The virtuous clinician takes more responsibility in the interactions with others, including their patients and other clinicians; this is through a deeper understanding of others, gained through participation in debates and appraisal of others whilst reflecting on one's own reasoning and actions.

Experiences enable the individual to develop their own self-concept and to maintain an evolving self-image of whom they are. Given the right conditions, with imagination and a self-belief as to who they can become, ethical virtues help motivate to reach goals; for instance, to overcome illness or in the case of clinicians, to offer more just and compassionate care. Such creative potential is more likely to bear fruit within settings where one is able to discuss and debate their perceptions and projects. Not only do these nurturing ongoing interactions sustain and develop one's self-image, they also facilitate healing and recovery from illness, allowing patients to develop their potential in life.

Healthcare delivery is regularly subjected to questioning through audits that represent an impersonal care improvement process. As society faces

ever increasing financial and resource pressures, there is a need to prioritise and focus on 'the who' rather than 'the what' in care delivery. There needs to be more emphasis on the quality of personal relationships between those giving and those receiving care. Such a focus requires all clinicians to reflect on their own motivations, on their character and their use of ethical virtues. Through reflective practice and case discussions, clinicians can be thought to develop such virtues. Within the constraints imposed on today's cost conscious health provision, the best clinical outcomes come to be achieved through improvements in the relational dimensions of mental healthcare, including improvements that focus on the coproduction of formulations and action plans with patients. These dimensions will now be further explored in the following two chapters.

Chapter 3: Illness and Ethical Virtues: A Phenomenological Interpretation

3.0.0 Introduction

The origin of the word disease comes from the French *desaise*, alluding to a lack of ease or a lack of comfort relative to an earlier time. I will here discuss how ethical virtues, phenomenology and psychiatry are intrinsically interlinked within modern psychiatric care. During illness, use of the person's virtues can become defective under the effect of distorted cognitions and perceptions. However, in all but the most extreme cases, there remains enough relatively intact virtues and elements of one's personality make up to serve as motivators for recovery. Through the use of empathy, the virtuous clinician will map the patient's remaining virtues onto their own settled virtues; utilising a process of phenomenological enquiry facilitates the co-production of a treatment plan that takes full advantage of the patient's remaining strengths of virtue.

Through training, clinicians tend to be virtuous; however, they can become more clinically effective when they develop their ethical virtues, including those of empathy and compassion. Clinicians direct care towards a desired and healthier version of the patient's self, through an understanding of the patient's *life-world*, one's everyday lived experience. This adds understanding of the patient's *life-narrative*, the story that provides direction towards a final aim in life. Treating a disease through shared goals, the patient and clinician together perceive what is

needed for the patient's future flourishing. The ultimate goal of such interventions is to build resources that will sustain the patient's recovery, building their resilience to the impacts of illness into the future.

3.1.0 Psychiatric Settings

3.1.1 Clinical context

As a practising psychiatrist, I encounter those suffering from complex mental health conditions whereby comorbidities such as intellectual disability, autistic spectrum disorder, anxiety disorders and depressive illness, often co-exist with physically disabling conditions such as epilepsy. Such complexity predisposes patients to becoming hermeneutically disadvantaged, whilst they struggle to express how they experience their worlds. Many such patients also have a limited opportunity to dare to dream or to act, as many are often surrounded by well-meaning family and other carers harbouring feelings of guilt in regard to the patient's disabilities. Such feelings can then lead carers to use compensatory over-protection that stifles the patient's independence, voice and empowerment.

The Community Mental Health Transformation Programme in England aims at offering further treatment choices and opportunities, in the least restrictive settings within the community.²⁷ What, in my view remains unclear within this initiative, is how such goals that rely on better social cohesion can be achieved without other changes within the social

²⁷ NHS England. 'NHS England Community Mental Health Transformation Programme - NHS partnership working with the third sector.' 23 February 2023.

sphere. In this chapter, I support the thesis that an enhanced use of ethical virtues leads to further provision of shared community goods which can then support and offer valuable positive life-experiences to those struggling with mental illness.

3.1.2 What encompasses mental disorder

The extent disorders of the mind rely on social constructs instead of being predominantly of biological origin, remains the subject of debate. In the prevalent psychiatric classificatory systems, diagnoses refer to entities that are subject to periodical changes in later versions of the manual, reinforcing a social conception of mental illness. For Eric Matthews commenting on Merleau-Ponty, deviations in one's moral vision are however what equates to an individuals' mental illness.²⁸ Not only does the experience of symptoms make the present experiential way of life differ from that experienced before the illness, but the experience of symptoms substantially influences whether and the extent to which one leads a flourishing life.

Psychiatric disease brings together a combination of biopsychosocial factors and experiential distress; all these require to be taken into consideration in the diagnostic and treatment processes. Mental disorder often leads to insidious but persistent changes in the way one thinks, reasons, feels and acts in the world. Such changes present

²⁸ Eric Matthews. 'Mental Disorder: Can Merleau-Ponty Take Us Beyond the "Mind-Brain" Problem?' In *The Oxford Handbook of Philosophy and Psychiatry*. Edited by K.W.M. Fulford et al. Oxford University Press, 2013: pp.531-544.

personal and social impacts that are deemed to be susceptible to improvement with treatment and supports.

3.2.0 Phenomenological Approach to Mental Disorder

3.2.1 Phenomenology: an outline

Psychiatric phenomenology emphasises the lived experience element of a patients' life rather than simply holding to the clinical identification of symptoms. In endorsing the view that mental illness is rooted in human experience, all psychiatric care ought to take subjective aspects of illness into account. Phenomenological psychopathology aims at understanding the structure of the patient's world, exploring what it is like to feel and live through having a mental disorder. Life-world exploration requires to be carried out in a way that maps onto the modern classificatory diagnostic categories. Such exploration can be through the use of Edmund Husserl's structural features of human experience and existence, noting changes in affectivity, temporality, selfhood and intentionality.²⁹ Phenomenological psychopathology serves as a way to

²⁹ Roberta de Monticelli. 'Edmund Husserl.' In *The Oxford Handbook of Phenomenological Psychopathology*. Edited by G. Stanghellini et al. Oxford University Press, 2019: pp. 11-19. Edmund Husserl developed the concept of 'unity of containment,' whereby there are bonds about the possible covariation of contents. The essence (eidos) of a thing is not a separate universal; there is only a bond, a constraint on possible variations of a things' content, also known as its eidetic structure, beyond which a things ceases to exist. The self is prior to the construed thus saving the phenomena and the richness of the sensible world. When we encounter another person, we adopt a personalistic attitude which is different from that we take for instance towards objects. We acknowledge other's sensibility and power through the use of empathy. Whilst immersed in reality, 'bracketing' allows us to reflect on our interactions with others and the world. We build and develop reality as a 'horizon' of our corrected perceptions. We explore these horizons and can correct falsities or doubts through reason. Consciousness is under the jurisdiction of reason; reality has a number of covariables the main ones being: the structure of the lived space, the structure of the lived time, structures of intersubjectivity and the basic self-constitution. A major alteration of the norm can occur along any of these axes, issuing in a different style of lived experience. The constitution of a common intersubjective world and the constitution of oneself ultimately depend on primary intersubjectivity.

understand the diversity of experiential alterations whilst bracketing over viewpoints, including scientific ones, about what is abnormal. It connects understanding with caring, thus establishing an ethical framework for the care of the diseased person.

3.2.2 Diagnostic critique

The practice of diagnostic and treatment algorithms dominates current psychiatric practice. During the clinical engagement, the clinician is here presumed to remain neutral to the patient's narrative and experience of disease. Good psychiatric care should require that the settled moral virtues of the clinician, in particular those of empathy and compassion, support patients during elements of phenomenological inquiry. In this latter process, patients describe their experiences throughout illness, including the meaning they make of them.

Classificatory systems in psychiatry typically rely on an operationalism whereby conditions are identified by reference to sets of observable symptoms. This holds for both the American Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, (DSM-5),³⁰ and the International Classification of Disease, 11th Edition, (ICD-11).³¹ In both instances, a specified number of symptoms have to be present for a set period of time before the diagnosis can be made. Such classifications are geared towards their practical utility, namely their value in identifying conditions that follow certain trajectories, prognoses and likely responses to forms

³⁰ American Psychiatric Association. *Diagnostic Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*. 2013.

³¹ World Health Organization. *International Classification of Disease, 11th Revision (ICD-11)*. 2022.

of treatment. Their application does not however necessitate an exploration of the person's life experience through disease.

Such operational approaches pose a number of limitations, not least the fact that in the main, psychiatrists typically perceive illness presentation in their patients as some particular whole kind of preconceived condition, that they can recall from previous training or experience. Psychiatrists tend to later check if their initial perception was correct, by verifying identified symptoms with operational criteria. The process of checking facilitates the expansion of the clinician's knowledge and understanding of the condition, for use in subsequent clinical interactions. This practical approach to diagnosis is akin to how in normal life, we perceive, typify and make sense of the world, allowing one to reflect and act on initial perceptions.

The main classificatory systems neglect to consider any organisation between symptoms, considering symptoms as disparate parts rather than part of a unified whole as experienced by the patient. Such systems pose the risk of creating a status quo, whereby diagnostic categories reify, risking inhibiting future alternative conceptualisations of disease.³² They also struggle to explain how diagnoses in psychiatry are frequently fluid, whereby symptoms and their manifestations in the same patient tend to vary over time, akin to the original description of social phenomena, as offered by Maximillian Weber.³³

³² Antony Vincent Fernandez. 'Phenomenological Psychopathology and Psychiatric Classification.' In *The Oxford Handbook of Phenomenological Psychopathology*. Edited by G. Stanghellini et al. Oxford University Press, 2019: pp. 1016-1030.

³³ Maximilian Weber. *The Methodology of Social Sciences*. Edited by H.A. Finch & E.A. Shils. Free Press, 1949. Weber, considered as the founder of modern sociology, argued that social phenomena

3.2.3 Experiencing disability

Disability of whatever type or degree, is socially constructed and only exists within contingent relations of social power. It is conceived as a misfortune leading to economic, social and political disadvantages together with an assumption that it is a defective entity, that ought to be corrected, prevented, cured or eliminated. For Shelley Lynn Tremain, the disabled represent a vulnerable group within the general population, whereby the creation of bioethics allowed the rest of the population to become normalised. This was created so as to make the population more governable and manageable.³⁴ Phenomenological descriptions can however serve as a means to outline co-produced interventions with the individual concerned so as to overcome the disabling elements of their mental illness.

The social perceptions of disability are influenced by the media, that often promotes conflicting but generally derogatory views about the mentally ill, leading to many who are experiencing mental health problems to hesitate seeking psychiatric supports. This behaviour risks disempowering people suffering from mental conditions, since it suggests that they cannot help themselves or are perhaps not

cannot be classified in the same way as natural objects. To better explain social phenomena, Weber developed the notion of the ideal type which he defined as one 'formed by the one sided accentuation of one or more points of view and the synthesis of a great many diffuse, discrete, more or less present and occasionally absent concrete individual phenomena, which are arranged according to those one sided emphasized viewpoints, into a unified analytical construct. In its conceptual purity, this mental construct cannot be found empirically anywhere in reality. It is a utopia.' Karl Jaspers, considered as the father of psychopathology, built and adapted on Weber in his work.

³⁴ Shelley Lynn Tremain. 'New Movement in Philosophy; Philosophy of Disability.' In *The Bloomsbury Guide to Philosophy of Disability*. Edited by Shelley Lynn Tremain. Bloomsbury Academic, 2024: pp.1-16.

accountable for their actions, raising questions about the disabled person's perceived worth in present day society.

The World Health Organisation, defines health not as the absence of disease but a state of complete physical, mental and social wellbeing; disability is furthermore defined as an interaction between health conditions, environmental factors and personal factors.³⁵ Any two individuals becoming ill, but who are surrounded by different environmental factors, will experience disability differently, depending on such factors as their social supports, the level of stigma and the physical affordances of their environment. Virtue ethics supports how the diseased individual relates to their suffering, identity, choices and community. It helps in the process of rebuilding a meaningful life, whilst one continues to manage their symptoms.

Many seek to understand themselves and for others to understand them, through psychiatric identities. They may perceive themselves as being disabled through an illness, perhaps as a way to justify a fear of not being able to meet certain self-imposed expectations in life. Psychological and social stressors have led to a rapid increase in rates of mental illness, including Anxiety, Depressive, Traumatic Stress, Attention Deficit Hyperactivity Disorders and to mental burnout. Such threats in modern life have given rise to calls for a 'Positive Psychiatry', one that seeks to understand and promote wellbeing through assessments and

³⁵ World Health Organization. *International Classification of Functioning, Disability and Health (ICF)*. 2001.

‘interventions aimed at enhancing behavioural and mental wellness.’³⁶ I will now proceed by exploring specific life-worlds that can help clinicians better understand what can reduce suffering during illness.

3.2.4 Life-world in schizophrenia

Life-world *existentials* are descriptions that define key aspects in the life of the diseased individual, leading to an understanding of the significance of the condition in that patient’s life. They are obtained through detailed phenomenological enquiry by clinicians who ideally hold stable ethical virtues such as those of empathy, kindness and compassion.

Louis Sass and Josef Parnas,³⁷ have built on concepts initially developed by Karl Jaspers, whereby schizophrenia was conceived as the loss of the ‘I’ quality of experience. They defined it as a disorder of *ipseity*, a core self-disturbance, having three concomitant interrelated aspects, namely hyper-reflexivity, diminished self-presence and a disturbance of grip on the perceptual and cognitive world.

Ipseity thus refers to having a sense of self-sameness when existing as a subject of experiences, whilst ‘serving as a vital centre point of subjective life’.³⁸ Hyper-reflexivity alludes to an exaggerated self-consciousness,

³⁶ D. V. Jeste et al. ‘Positive Psychiatry: Its Time Has Come.’ *The Journal of Clinical Psychiatry*, 76, (2015): pp. 675-683. This increase in rates of illness, particularly in the younger population, is potentially due to many younger persons being less adapting to an ever increasing list of challenging life circumstances.

³⁷ L.A. Sass & J. Parnas. ‘Schizophrenia, Consciousness and the Self.’ *Schizophrenia Bulletin*, 29, (2003): pp. 427-444.

³⁸ Louis Sass. ‘The Life-World of Persons with Schizophrenia’. In *The Oxford Handbook of Phenomenological Psychopathology*. Edited by G. Stanghellini et al. Oxford University Press, 2019: pp. 597-618. In schizophrenia, disturbances impact on motivational drives and on how one organizes their experiential world in line with their needs and wishes, thereby giving objects their affordances

whereby phenomena that would otherwise remain in the implicit background of experience, whence they were experienced as part of the self, now become experienced as having an alien quality, such as when inner speech is perceived as auditory hallucinatory experiences. Diminished self-presence points to a reduction in the experienced sense of being the subject of awareness or the agent of action, whilst a disturbed grip on the cognitive perceptual world refers to a disturbance in the spatio-temporal structuring of the experiential field. Such abnormalities of the embodied experiencing self, impact the constituting and orientating background of one's experiences, causing distress.

3.2.5 Life-world in autism

The life-world of people with autism is characterised by divergent sensory and perceptual ways of experiencing the world. In the typically developing child, there are biological prerequisites that allow the child to harmonise with caregivers through embodied mimetic attuning, such that the child will absorb meaning, rules and behavioural codes. Such abilities are markedly compromised in autism, impacting on one's social interactions in a way whereby it becomes difficult to grasp or imagine another person's motives.³⁹ These contribute to problems in integrating attentional, cognitive and affective factors, as well as difficulties with

or importances, for instance as tools, obstacles or as objects of desire. Furthermore, diminished self-presence leads to a blunting of emotions and to a feeling of estrangement and detachment from one's mind, body and the external world. This can lead to feelings of despair and suicidality. Both positive symptoms such as delusions and hallucinatory experiences as well as negative symptoms, such as affective blunting, make it hard for the person to identify reality and to make decision based on it. Estrangement from one's mind leads to reduction in social interactions, reduced emotional expression as well as to reductions in general levels of motivation.

³⁹ Francesco Barale et al. 'The life-World of Persons with Autism.' In *The Oxford Handbook of Phenomenological Psychopathology*. Edited by G. Stanghellini et al. Oxford University Press, 2019: pp. 695-709.

having the intuitive ability to predict what will likely follow in a given situation.

Withdrawal from others becomes both a primary and a secondary characteristic, the latter often arising due to social fears, feelings of powerlessness and fears of humiliation. Repetition and set routines fulfil a basic need for organisation in a world of fragile predictability; they serve as an attempt to re-organise the space-time continuum that otherwise can slip into chaos. Crises can follow when there are disruptions to sameness and routines. There develops a preference for rigid and unmodifiable patterns of interactions in the exchanges between the self and the world. Additionally, immediate responses cannot be inhibited and adjusted according to circumstances, such as in response to another's emotional reactions, resulting in behaviours that may challenge the other's understanding.

3.2.6 *Life-world in intellectual disability*

Individuals with intellectual disability are more likely to compare themselves with others without such conditions, resulting in self-questioning and doubts about their place within society. 'The disabled person maintains a reduced narcissistic resilience with a damaged and fragile sense of self,' claim Bertelli et al.⁴⁰ This impacts on one's decision making, affecting their dreams, ambitions, desires and the fight for their rights. One risks learnt helplessness about future possibilities, with

⁴⁰ Marco O. Bertelli et al. 'Phenomenological Psychopathology of Neurodiversity.' In *The Oxford Handbook of Phenomenological Psychopathology*. Edited by G. Stanghellini et al. Oxford University Press, 2019: pp. 1078-1108.

expectations of negative future outcomes and expectations of future adversity.

In contemporary society, they frequently have to face the belief that one should not allow people with intellectual disabilities to make decisions that can lead to mistakes resulting from their poor judgement. Nevertheless, all human learning takes place through the decisions that individuals make, some being right decisions, others wrong. To treat people with disabilities as equal in value, they are to be allowed to make mistakes including in their social exchanges. Practical supports and the use of ethical virtues, including those of tolerance and compassion can help to mitigate such errors of judgement. To be able to understand one's life-world goes a long way in treating disease, without resultant epistemic injustices.

3.3.0 Virtue Ethics and Phenomenological Psychopathology

3.3.1 Virtue ethics in aid of phenomenological psychopathology

Phenomenology allows clinicians to get to understand what illness is like from a first-person perspective; elucidating such an understanding requires the clinician to exhibit moral dispositions such as provided through the ethical virtues. These serve to bridge the potential gap in epistemic understandings of illness between the patient and the clinician. Recognising the other as an autonomous person during phenomenological enquiry is an ongoing process of understanding and interacting, a relation with one who has particular past and current experiences, as well as particular ideas about life. Virtue ethics,

envisaged by Aristotle, grants others moral standing when one considers the possible current and future impacts of what they do or say. During interactions, clinicians strive towards the objective of achieving human flourishing, inclusive of achieving physical and mental wellbeing.⁴¹

Virtues are dispositions of excellence that one chooses according to reason and that are developed through learning from others or from reflections on past choices. The ethical virtues concern actions and emotions and lead to practical wisdom, whereby one gets to understand and to consider the most salient features of any given situation, including one's environmental care responsibilities.⁴² Clinicians can consolidate their practical wisdom through a process of ongoing reflection, whereby one critically analyses their beliefs, actions and assumptions about past and ongoing clinical interactions. In further support of this, Rosalind Hursthouse defines ethical virtues as traits that guide actions, to promote both one's and the other's survival; in so doing, one promotes social cohesion, freedom and enjoyment.^{43 44}

Meanwhile, Martha Nussbaum perceives that we are immersed in the world from which we pick up key spheres of experiences, a 'thin edge' of

⁴¹ Alasdair MacIntyre. *Ethics in the Conflict of Modernity*. Cambridge University Press, 2016 : pg. 54. MacIntyre emphasises how eudaimonia is a state in which one is and feels satisfied with one's condition only because one has good reason to be and to feel satisfied. For Aristotle however, eudaimonia represents the ultimate and highest good in a life that is flourishing, fulfilling and that goes well. It is not an end but it is rather a happy ending; to fail to achieve it is to die unhappily.

⁴² Robin Attfield. *Ethics: An Overview*. Bloomsbury, 2012: pp. 5-8.

⁴³ Rosalind Hursthouse. *On Virtue Ethics*. Oxford University Press, 1999.

⁴⁴ Rosalind Hursthouse & Glen Pettigrove. 'Virtue Ethics'. *Stanford Encyclopaedia of Philosophy*. Stanford University, 2022. Hursthouse defines virtue ethics in terms of their relationship with eudaimonia. A virtue is a trait that contributes to or is a constituent of eudaimonia and we ought to develop such virtues. For the stoics and Plato, a virtue is both necessary and sufficient for eudaimonia. For Aristotle, virtues are just character traits that barring bad luck, benefit their possessor in reaching eudaimonia. Such bad luck may include the onset of mental illness.

grounding experiences that we continue to elaborate on with others, developing more elaborate ‘thick edge’ revisions, through the use of virtues. This happens in line with new evolving understandings.⁴⁵ Clinicians can start to gain an understanding of the patient’s illness experience within the contexts and relations where they are assessed; these understandings are apt to significantly differ depending on one’s later settings.⁴⁶

Perceived gaps in epistemic understanding between clinicians and patients pose risks to phenomenological inquiry; the patient’s account of the personal experience risks being invalidated as the patient potentially acquiesces to the clinician’s misinterpretations. However, a clinician with developed ethical virtues can reduce such a risk through regular checking of their comprehension, ensuring that it is the patient’s true account that is being elucidated through the use of the virtues of empathy, warmth and trustworthiness. As Rene Rosfort highlights, treating a patient involves a clear understanding of what it is that the patient cares about.⁴⁷ Physicians are also however required to safeguard the autonomy of patients and to be able to adopt an impersonal perspective on the patient’s suffering, allowing them to diagnose and treat patients even when this goes against the patient’s understanding of their suffering.

⁴⁵ Martha Nussbaum. ‘Non-Relative Virtues: An Aristotelean approach.’ In *The Quality of Life*. Edited by Martha Nussbaum & Amartya Sen. Clarendon Press, 1993: pp. 242-269.

⁴⁶ Maren Batalden et al. ‘Coproduction of Healthcare Service.’ *BMJ Quality & Safety* (2015). Coproduction is the elaboration of a shared understanding between clinicians and patients.

⁴⁷ Rene Rosfort. ‘Phenomenological Psychopathology and Psychiatric Ethics.’ In *The Oxford Handbook of Phenomenological Psychopathology*. Edited by G. Stanghellini et al. Oxford University Press, 2019: pp. 972-986.

3.3.2 Narratives and identity

For MacIntyre, ethical virtues make sense within practices, including how clinicians act towards patients or how we interact in the social community.⁴⁸ They provide meaning to the reflective agent, allowing them to understand themselves and others through their own or others life narratives. Such narratives provide a story where one directs or fails to direct themselves towards a final aim, the nature of which can be understood in and through one's activities as rational agents.⁴⁹

Our identity is in part constituted by narratives we tell ourselves and with which we become entangled. Paul Ricoeur allows narratives to be used to cope with the sense of passivity as experienced in illness, through an engagement with structures such as psychiatric care. The work of the virtuous psychiatrist is required so that the patient is able to reappropriate their fragile identity.^{50 51}

⁴⁸ Alasdair MacIntyre. *After Virtue* (3rd Ed.). University of Notre Dame Press, 2007. For MacIntyre, virtues are qualities necessary to achieve the goods internal to practice, leading to contributions towards the good of one's whole life. They are furthermore used in pursuit of all human goods within the social communities. No human quality can be said to be a virtue unless it satisfies these three elements. One gets to apprehend how to live through the development of their identity and through individual narratives that provide a longer-term perspective on one's life. These are subsequently recurrently verified through one's ongoing social interactions. Practical reasoning allows for the ongoing ordering of desires; however, one's moral agency can be threatened by an incoherence of desires in mental illness, such as for instance in schizophrenia, whence any such incoherence is experientially frustrating. Adopting the ethical virtues allows one to achieve flourishing through the pursuit of internal goods that maintain the coherence of one's narrative in the face of external threats. The onset of mental illness can however negatively impact on one's ability to maintain a coherent life narrative, their self-identity and ultimately, their flourishing.

⁴⁹ Alasdair MacIntyre. *Ethics in the Conflict of Modernity*. Cambridge University Press, 2016: Pg 54.

⁵⁰ Rene Rosfort. 'Paul Ricoeur'. In *The Oxford Handbook of Phenomenological Psychopathology*. Edited by G. Stanghellini et al. Oxford University Press, 2019: pp. 72-79.

⁵¹ Paul Ricoeur. *Oneself as Another*. University of Chicago Press, 1995. Here Ricoeur identifies an *idem* identity, which includes stable characteristic traits versus an *ipse* identity, which refers to a temporal and reflective self in relation to the experiencing of another. Selfhood implies otherness; one is oneself inasmuch as being another.

3.3.3 Critique of virtue ethics

Foucault cautions that the use of virtues is moralistic and judgmental;⁵² however, most psychiatrists can be seen to rely on altruistic commitments towards the patient's wellbeing, particularly when they consider how mental illness affects the way patients act.⁵³ Virtue ethics has furthermore been seen as a rule based procedure that determines the right action to the particular situation. Such criticism is unjust as there can never be such generalisation of responses in clinical care, where it will be virtually impossible to develop an ethical code in regard to all phenomenological experiences.⁵⁴ Moral sensitivity, imagination and judgements informed through experience, are necessary clinical elements leading to correct virtuous considerations.

With the notable exception of when there is evidence of a lack in one's mental capacity, we all are responsible for our own choices throughout our adult life. Jean-Paul Sartre cautions us about excessive virtue usage, including the virtue of compassion towards capacious others. Use needs to remain tempered by an awareness of limits as to what is within one's remit so as not to infringe on the other person's rights on what to decide.⁵⁵ Such tempered compassion will allow patients to decide on how their individualised treatment plan progresses in an authentic person centred manner.

⁵² Michel Foucault. *Madness and Civilisation*; 2nd Ed.. Routledge, 2001.

⁵³ John Raymond Peteet. 'The Virtues in Psychiatric Treatment.' *Frontiers in Psychiatry* (2023).

⁵⁴ John McDowell. 'Virtue and Reason.' *The Monist*, 62 (1979): pp. 331-350.

⁵⁵ Jean Paul Sartre. *Critique of Dialectical Reason* (Complete Edition). Verso Books, 2022.

3.4.0 The Clinical Interphase

3.4.1 Virtue ethics in clinical practice

In the following sections, I will further build on how ethical virtues can be utilised in developing both internal and external resources with those suffering from mental illness. Virtue ethics offer the possibility for one's life experiences to be given meaning through their interactions with others; such meaning can also come about within the therapeutic environments. Ethical virtues as beheld by all those around us, help consolidate social cohesion, facilitating the communication of one's needs. Ethical virtues internal to the patient can help keep desires and impulses that occur during an episode of mental illness under a degree of reflective review, further allowing insights that can help towards the setting of recovery targets. Initial success in virtue use, can enhance one's motivations to keep engaging in the care process, thus enabling the development of mental resilience that counters future adversity.

Throughout an episode of mental illness, one's life narrative elucidates what they hold themselves accountable for, providing the drive and courage to persist and to overcome disease. Whilst acknowledging the need to develop ethical virtues, the patient primarily directs their use towards themselves, such as for instance through self-consideration with compassion, forgiveness and gentleness rather than judging themselves too harshly, exacerbating such conditions as depression or eating disorders. Successful use of the ethical virtues also directs patients to treat others in the same way as they would like to treat themselves,

leading one to not being overly critical in considering other's contribution towards the disease episode.

Following Aristotle's concept of the golden mean, a balance between reflection and self-criticism helps one identify the virtuous range in a particular context. Excessive self-criticism can exacerbate depression and exhaustion as one strives for the perfect solutions; on the other hand, excessive use of the virtue of perceptiveness to the fate of others can become an impediment to one's recovery efforts. Elsewhere, a lack of self-criticism can lead to a disregard to the effect of one's acts on others. Reflective practice facilitates the identification of the golden mean; it elucidates how to moderate and balance the use of virtues, identifying when and how to use virtues within context. Developing the use of ethical virtues, including that of reflection, helps to directly serve clinicians, allowing them to flourish whilst helping to reduce their own risks of burnout.

3.4.2 Therapeutic implications

Phenomenological inquiry facilitates therapeutic processes that allow patients to develop their ethical virtues, such as through the insights patients gain about perceived stable virtues that their clinicians put into practice. Through being helped to develop their ethical virtues, patients are also helped in their overall wellbeing. Virtue ethics can serve to help situate the patient within their social network, instilling a sense of duty both towards the self and towards others; this for instance supports adherence with agreed care regimes.

MacIntyre considers that one's understanding of shared goods within their virtuous social sphere facilitates better access to support networks. Within one's social group, there resides the help that can ensure a person's continued ability to find meaning. Others within such virtuous social networks are more likely to value the ill person's contributions towards the common goods. Such networks of support therefore provide opportunity for members to serve both as a sounding board and as a helping hand towards illness recovery.⁵⁶ Networks of support within the community that practice virtue ethics can therefore help achieve the stated aims of the Community Transformation agenda.

The 'fourth wave' of psychological interventions aims not just at focusing on psychopathology but also towards a vision of human flourishing through the development of one's virtues. These interventions build on Jean-Paul Sartre's existential psychoanalysis, whereby the non-thematised, pre-reflective aspects of consciousness and experience are articulated into explicit narratives, such that patients can take responsibility for their choices rather than viewing their actions as being driven by hidden motives.⁵⁷ Fourth wave treatment interventions include Compassion Focused Therapy, which builds on the concept that good mental health and recovery are supported through having a good moral character, as based on virtue ethics.⁵⁸

⁵⁶ Alasdair MacIntyre. *Dependent Rational Animals: Why Human beings Need the Virtues*. Duckworth, 1999.

⁵⁷ Jean-Paul Sartre. *Being and Nothingness*. Routledge, 2003.

⁵⁸ Paul Gilbert. *The Compassionate Mind* (reissued). Robinson, 2010. In such a therapeutic process, development of practical wisdom allows patients to learn how to overcome hyperarousal and fear.

Patients are also supported to place experiences in perspective within their own life narrative. Patients can then become more accepting and truthful about their experiences, including in regard to ongoing symptoms that could indicate illness relapse. Greater illness insight can also be obtained through ongoing facilitated learning about the illness. Furthermore, such insights help highlight the effects that illness has on others, including impacts on family members or the effects environments have on illness, such as the effects of heightened expressed emotions that can delay recovery. Such treatments also help patients remain grounded in reality, reducing risks that arise from the isolation problem, whereby one risks becoming detached from the external world in one's belief making processes. Furthermore, educational interventions can help facilitate patients to talk about fears related to the experience of medication side effects. This, alongside the ethical duty to get better, can help with overall treatment compliance.

3.4.3 On human emotions

Virtue ethics can help one to faithfully interpret, assign value or significance to ongoing illness experiences. Reflective practices remain limited when one's life is going well, since one will not dwell further about the coherence in their narrative. When faced with adversity however, one tends to further their reflections through an inner dialogue, under emotional influences that encompass ongoing adverse experiences. Emotions can be seen as feelings of bodily changes, whereby the body reacts to a perception of the external world before

one can reflect on the linked internal perceptions.⁵⁹ Thereafter, discipline imbued through practical wisdom and reflection as taught during psychological therapies, can serve one to better understand and be able to modulate their emotions.

Ethical virtues help facilitate the development of other values. As one values safety for instance, the development of the virtue of caution allows one to navigate more safely in their worldly contexts. Valued objects of belief tend to cluster around specific memorised emotions; for instance feeling calm is linked with the value of security. Emotions impact on how one perceives their world; however, one's emotions can be modulated through virtue use. The constancy of the virtues pulls back on an emotional push, allowing for ongoing coherence to one's emotive narrative and identity. For Ratcliffe, Husserl's horizontal structures of experience entail not just what is experienced through perception, but also the sense of perceptual possibilities. It is within the patient's power to determine which health possibilities to aim for whilst aided by ethical virtues such as those of hope and courage.⁶⁰

⁵⁹ William James. 'What is Emotion?' *Mind* (1884). In this classic text, James argues that bodily changes occur first after a perception of an event, and that emotions occur subsequently when we feel changes in our bodies related to this perception. In this regard, he is most famously quoted as saying that 'We feel sorry because we cry, angry because we strike, afraid because we tremble'.

⁶⁰ Matthew Ratcliffe. 'Existential Feeling and Psychopathology.' *Philosophy, Psychiatry & Psychology* (2009): pp 179-194. Ratcliffe outlines existential feelings as structures of relatedness between the self and the world which build on Husserl's constitutive analysis around the changeable sense of reality, situatedness, locatedness, connectedness, significance and so on. Ratcliffe also builds on how we experience the world, such that; 'bodily feelings just are...ways in which the world appears.'

3.3.4 Critique of phenomenology

Phenomenology has been criticised as being excessively subjective and solipsistic, marking a gap between the subjective experience and the social structures within the objective external world. It is also criticised for not being able to explain the aetiology of how a diseased person so feels. However, further ongoing research within psychiatry can help identify the influence that ethical virtues can have on the phenomenological course during one's illness. Research on the effects of the virtues can even focus on the impact of specific virtues, such as the virtue of hope, on the course and experience of a specific mental illness, for instance schizophrenia.

Such research can help extend the conceptualisation of mental healthcare, potentially into one of life adjustments, including adjustments to disability and to trauma. Furthermore, such re-conceptualisation can be extended to encompass factors that impact on one's perception of disease, such as how social inclusion facilitate the building of self-esteem, self-help and wellbeing as attested by Ratcliffe who states that; 'Experiences, thoughts and activities are shaped and also regulated by relations with other people.'⁶¹

Clinical training ought to more specifically teach clinicians how to enhance their ethical virtues, including those of empathy, reflection, compassion and humility. Such teachings can be reinforced through

⁶¹ Matthew Ratcliffe. *Grief World: A Study of Emotional Experience*. MIT Press, 2023. Nevertheless, regardless of what life experiences and care one is provided with, past dreams, hopes and the pre-diseased way of life will continue to have an effect on how the person experiences their world.

practical training experiences, such as through working alongside practitioners who have mastered utilising such ethical virtues in their patient therapeutic alliances. Donald M. Berwick, also points us towards a model of future mental healthcare where morality, particularly the meaning and significance of care within a person centred care model, becomes what drives psychiatric practice.⁶²

3.4.0 Conclusion

Hermeneutical injustices occur when mentally ill individuals are systemically denied access to understandings that can lead to treatments crucial for their flourishing, including the possibility of developing skills, cognitions and virtues that enable recovery. In being epistemically disadvantaged, there are risks that the patient agrees and conforms to the wrong treatment plans, ones that ultimately are not in their best interest to follow. Whereas mental illness affects a patients' character including their use of virtues, phenomenological inquiry helps identify the remaining elements of character and virtue on which the ethically virtuous clinician can help found meaningful treatment interventions. Shared social meanings, ethical virtues, social cohesion and valued roles in society can all help the recovering patient to become more at ease with their lives as they overcome the impact of mental illness.

Today's care delivery models give rise to an increased risk of burnout in clinical staff, potentially as a result of the moral distress they experience.

⁶² Donald M. Berwick. Era 3 for Medicine and Healthcare. *JAMA* (2016): pp. 1329-1330.

Such distress can be alleviated where clinicians are better trained in using ethical virtues whilst continuing to adhere with work productivity demands. Such demand constraints often do not take into account how much clinicians learn about themselves through interactions with their patients over periods of time. Developing one's ethical virtues is particularly relevant for mental health professionals, who are particularly at risk of finding themselves working in settings that engender epistemic injustices towards their patients, such as if one treats a patient narrative as being unreliable.

There is ongoing debate on whether the risk of epistemic injustices are increased when patients get diagnosed and are then treated solely through the use of algorithmic Artificial Intelligence (AI), running on probabilistic interpretations and correlation of patient reports, rather than on a humane empathic understanding of the self through experiencing the other. National mental health policies do not appear to place the necessary importance on phenomenological inquiry or towards the development of ethical virtues in therapeutic processes and appear to favour AI usage as it helps reduce waiting times for care. The onus to advocate for such services that promote time for phenomenological inquiry and understanding needs to come from clinicians and through the self-advocacy of their patients.

Ethical virtues, phenomenology and psychiatry are intrinsically interlinked within effective mental healthcare. Without realising this link, clinicians and care commissioners run the risk of creating novel epistemic injustices towards patients. Such risks can be reduced by training and

supporting clinicians in the use of ethical virtues during clinical interventions. Patients learn to map and develop ethical virtues as demonstrated by their clinicians, thus helping their recovery and inclusion back within social networks. In the following chapter, I will be further exploring on how clinicians can reduce risks of epistemic injustices.

Chapter 4: Virtues as an Antidote to Psychiatric Epistemic Injustice

4.0.0 Introduction

Psychiatry is primarily concerned with diagnosing and treating mental illness. Due to the complex nature of many mental health disorders, it traditionally adopts a multimodal, integrative and holistic approach to care, namely the biopsychosocial model. Such an approach is seen by some as being overly inclusive and expensive, arguing that psychiatry ought instead to use the more scientifically biased biomedical model, only giving secondary considerations to the other factors. Here, I begin to outline reasons for holding onto the biopsychosocial model, as when it is used in conjunction with virtue ethics and phenomenological engagement, it reduces risks of epistemic injustice within psychiatric care. It can however be acceptable to bypass detailed phenomenological inquiry in specific cases, to mitigate time and clinical risk constraints within contracted service deliverables.

In this chapter, I first set out an overview of demands on psychiatric care, followed by a brief outline of epistemic injustice and ethical virtues. In the following section, I outline the added value to care accrued from the use of ethical virtues and phenomenological engagement. The final two sections outline a normative account of elements in care delivery that can reduce epistemic injustice as this relates to life narratives.

4.1.0 Demands on Care Delivery

Mental illness presents a significant national economic burden, costing the UK economy some £300 billion or 5% of its GDP in 2022.⁶³ There are regular political initiatives targeting further efficiency in mental healthcare delivery. John Sadler however cautions that mental healthcare risks being the victim to moneyed elites who, having been able to frame the terms of scientific discourse, successfully marginalised alternative views to care delivery.⁶⁴ For various reasons, demands on mental healthcare remain on the increase, year on year.⁶⁵ In addition, every iteration of the DSM and ICD classifications adds new diagnoses linked to new pharmacological interventions, driving further requests for diagnoses and treatments.

Effective care within tight financial and time constraints continue to be informed through learning from previous models of care delivery; such learning helps, for instance, to reduce risks of injustices through stigma, neglect and abuse. Experiencing mental illness has long been associated

⁶³ Frederico Cardoso & Zoe McHayle. Centre for Mental Health, 24th March 2024. centreformentalhealth.org.uk. This figure of £300 Billion includes some £110 in sickness costs and unemployment, some £130 in reduced quality of life and premature mortality due to illness chronicity and some further £60 billion being the cost of supporting those with mental healthcare needs. These latter costs do not include the treatment costs. All these costs have increased significantly since.

⁶⁴ John Z. Sadler. 'Considering the Economy of DSM Alternatives.' In *Making the DSM-5 Concepts and Controversies*. Edited by J. Paris & J. Phillips. Springer, 2013. Sadler's model of this domination is through a 'Mental Health-Medical-Industrial Complex', whereby human problems are medicalized through a process of coming to be defined and treated as medical problems. This then allows commercial products and services to be sold as solutions to the human problems.

⁶⁵ Mental healthcare services received a record 5.2 million referrals in 2024, up 37.5% from 2019. BMA, 16th March 2026. bma.org.uk.

with an increased risk of suffering from injustices, including epistemic injustice as initially described by Miranda Fricker to which I now turn.⁶⁶

4.1.1 Epistemic injustice

Illness and recovery are frequently marked by altered experiences that one struggles to find words for and that contribute to *hermeneutical injustices*. Patients are also at risk of experiencing *testimonial injustice*, such as by being judged as lacking in mental capacity before they can properly explore or explain their rationales and behaviours. Such injustices then place patients at an increased risk of being treated under compulsion. Psychiatric patients are at risk of other injustices, including demands to return back to work whilst not fully recovered. The sanctioning risks from disclosing how the mentally ill person really feels, result into what Kristie Dodson defined as *testimonial smothering*. Here patients consider that it will be harmful for them to give testimony of their illness experiences since their audience are likely to be prejudiced against mental illness and furthermore, are unable to understand and be

⁶⁶ Miranda Fricker. *Epistemic Injustice; Power and the Ethics of Knowing*. Oxford University Press, 2007. Fricker refers to epistemic oppression as producing deficiency in social knowledge, leading to an infringement on the epistemic agency of knowers, thus reducing their ability to participate in relevant epistemic communities. This leads to unwarranted damage to the knower and to the state of social knowledge within shared epistemic resources. Fricker notes two forms of epistemic injustice, namely *testimonial injustice* and *hermeneutical injustice* and an outlying *epistemic bad luck*, which division was criticised amongst others by Kristie Dodson. Testimonial injustice occurs when prejudice causes the hearer to give a deflated level of credibility to the speaker's word whilst hermeneutical injustice occurs owing to some significant area of one's social experience being obscured from collective understanding owing to a structural identity prejudice in the collective hermeneutical resource. For Fricker, epistemic injustice is broadly construed as nonaccidental in the sense that a more virtuous person will recognise the affective investment and hermeneutical marginalization. Such injustices produce an epistemic inertia as well as epistemic harm to the knowers.

ready to believe an account of the ill person's perceptions and emotions.⁶⁷

Within the norms of British society, one finds the episteme of psychiatric care; this framework allows psychiatry to contribute to the common goods through the patient's recovery journey. This episteme refers to psychiatry's framework of knowledge whereby it has been criticised as being grounded on the objectification of patients, tending to rely more on patient observations and third party accounts rather than accounts of the patients' lived experience. Psychiatric practice risk minimising the role of the patient as a knower of their illness, expounding the risks of epistemic injustice.⁶⁸ However, a pedagogy of virtue ethics that initially targets mental health professionals will, through the care process, cascade down to patients and their carers; such an education ought to be a foundational element towards the epistemically just delivery of healthcare.

4.1.2 On defiance and giving uptake

In mental illness, there are many possible causes for defiant behaviour; for instance, it can be a way to avoid engaging in something that raises

⁶⁷ Kristie Dotson. 'Tracking Epistemic Violence, Tracking Practices of Silencing.' *Hypatia*, 2011. Dotson is here referring as to how members of oppressed groups get silenced with respect to testimony. Epistemic violence occurs as a result of the pernicious ignorance of hearers in regards meeting the vulnerabilities of speakers.

⁶⁸ Ethically provided care requires that one should receive effective treatments, whereby there is a balancing between patient rights and duties against those of society. Service users have a right to know their diagnosis and prognosis including what predisposes to illness relapses. There are several factors known to increase the risk of mental illness; the population deserves to better understand these risks in the context of modern day society. The general population deserves to know what one can do to reduce risks of becoming mentally ill, such as how to mitigate risks of social isolation or the influence of unfettered access to social media in the young, both known to increase predisposition to illness.

one's anxiety; alternatively it arises in response to threats to one's independence but at other times, it is the result of a patient becoming sceptical of the listener's ability to understand the knower. Nancy Nyquist Potter deems that defiance can serve as a virtue during mental illness. Here it signifies to clinicians that they need to be less judgemental in their evaluation of patient symptoms and behaviours.⁶⁹ For Potter, virtue ethics help serve patients to overcome their illness, throughout the entire recovery journey.

Psychiatrists are to develop the virtue of *giving uptake* to the patient's narrative, in a way that validates the patient's experiences, engendering trust that helps build up solid engagement with treatments that are in line with the patient's understanding of what will help them recover from disease. For Potter, giving uptake to the patients' narrative meaning is key in the delivery of therapeutic healthcare.

Inequalities and systemic injustices remain endemic within society whereby structural barriers block the equal distribution of virtues required for good character development. Within one's culture, there are norms, such as those relating to one's working ability or to an inclusion within family life. A failure to sustain or to achieve such norms can lead to distress that risks being pathologized, where it gives rise to the illness. Life presents certain social situations whereby one cannot give an affirmative or negative answers, since both are wrong responses; for instance, manifesting distress can present a double bind, according to

⁶⁹ Nancy Nyquist Potter. *The Virtue of Defiance and Psychiatric Engagement*. Oxford University Press, 2016.

Jane Ussher. What stance should a patient take to the psychiatric episteme? Does one follow the patient role with an inherent subordination as seen in the traditional psychiatric episteme, or challenge the norms, with the risk of being labelled as being aggressive, noncompliant and defiant?⁷⁰ Both can be seen as having potentially negative impacts on the patient.

4.1.3 Burdened virtues in psychiatry

For Lisa Tessman, although one develops ethical virtues, these can prove to be a burden rather than a help. Such *burdened virtues* arise because of some injustice, thus failing to contribute to one's flourishing.⁷¹ A patient may for instance appear polite because of the fear that defiance will lead to a more prolonged hospitalisation. However, such politeness can erupt into frustration and defiance when the goal behind the virtue of politeness is unfulfilled. Following Tessman, clinicians should develop a disposition for delving into the significance of defiance within the patient's overall clinical presentation.

4.1.4 On autonomy and agency

Co-production of care plans alludes to a mutually agreed contract between a clinician and the patient; however, patients often report being unheard and coerced to ensure compliance with what clinicians deem best for them within the resources available.⁷² Experiencing mental

⁷⁰ Jane Ussher. *The Madness of Women: Myth and Experience*. Routledge, 2011.

⁷¹ Lisa Tessman. *Burdened Virtues: Virtue Ethics for Liberatory Struggles*. Oxford University Press, 2005.

⁷² K. Roed et al. 'Harmful Epistemic Practices in Antipsychotic Medication Prescribing and Counselling.' *Social Science and Medicine*, 2026. It is furthermore requested that mental health professionals must better respond to the epistemic resources of patients and to the specific

illness should not signify that a patient is not a potential knower of their aspirations, needs or experiences. After all, one's desire for autonomy and their sense of agency have to be regarded as two of the foremost qualities that make a life worth living, as Bernard Williams attests.⁷³ The virtuous psychiatrist is aware that the psychiatric episteme puts patients in a vulnerable position, in that it grants the clinician the claim of superior epistemic knowledge about one's illness, which as we have seen in earlier chapters, does not hold true. The psychiatric episteme can produce injustice as it can allow the coercion of patients to adhere to treatment plans, then deeming patients to be collaborative and respectful within therapeutic relationships.

Not all those experiencing mental illness choose to be treated when diagnosed; epistemic justice allows that within legal and ethical considerations, some can choose to remain, and cope with, being ill. Indeed, giving one the right to refuse a treatment can help develop or maintain the therapeutic relationship, claims Elyn Saks.⁷⁴ Over time, the defiant patient can become more informed in their decision making, such that they subsequently decide whether to adhere to treatment. The psychiatric episteme is nevertheless fundamental in sustaining our cultural norms; it forms part of the communal glue that holds our society together in a way that allows the sharing of goods that facilitate flourishing. In following Barbara Misztal's framing of society, any further

demands of particular situations in order to expand the epistemic resources and so as to enable a shared understanding of the actions that should be decided on.

⁷³ Bernard Williams. 'A Critique of Utilitarianism.' In J. J. Smart and B. Williams: *Utilitarianism: For and Against*. Cambridge University Press, 1973.

⁷⁴ Elyn Saks. *Refusing Care: Forced Treatment and the Rights of the Mentally Ill*. University of Chicago Press, 2002.

weakening of such a communal glue can give rise to suspicions and mistrust about psychiatry, potentially leading to losing psychiatry's protective practices that help ensure ethical healthcare.⁷⁵

4.1.5 Norms and psychiatry

Norms on how mentally ill patients should behave are produced by the dominant culture; these norms dictate our understanding of how we ought to think and act in our positions in life. Such norms include that of being a psychiatric patient. We instinctively follow norms that then hold us accountable to one another.⁷⁶ Multicultural society allows for norms from different cultures; for clinicians this can complicate their assessments as to why the patient is defiant, unless they are conversant in that patient's culture.⁷⁷ Western cultural norms require a deference towards clinicians that leads to compliance in care; however, clinicians should not assume that this attitude cannot be challenged by their patients.

Norms face an ongoing struggle with defiance from those who question their usefulness. This struggle maintains the sense of continuity granted by norms in the face of defiance or other deviant behaviours, claims

⁷⁵ Barbara Misztal. *Trust in Modern societies: The Search for the Bases of Social Order*. Polity Press, 1996. Misztal here argues that trust is a fundamental underpinning for social order. It underpins cooperation stability and social interactions.

⁷⁶ Geoffrey Brennan et al. *Explaining Norms*. Oxford University Press, 2013. Norms also dictate an attitude on how we experience and interpret others. Those who do not follow such norms can become targeted and shunned. For norms to have taken hold, a significant number within the dominant group must follow and know such attitudes.

⁷⁷ M.C. Fadus et al.. 'Unconscious Bias and the Diagnosis of Disruptive Behaviour Disorders and ADHD in African American and Hispanic Youth.' *Academic Psychiatry*, 2020. Diagnostic evaluation relies in part on the subjective interpretation of information by clinicians. Unconscious cultural bias leads to increased diagnoses of conditions linked with violent behaviours in minority groups with clinicians being less likely to consider alternative explanations for the behaviours.

Potter.⁷⁸ The patient role is then dictated by norms; norms however will impact and limit one's use of virtues. The patient role is furthermore influenced by one's moral and epistemic strengths. Aristotelian virtue is not just a quality of character but is also an intellectual one, whereby the latter abilities are required as one reflects on their actions.

Civility involves that one fully considers others, since every other human matters; it serves as a socialising mechanism that reinforces social relationships within one's group. Absence of defiance often signifies deference to authority but in psychiatry it may signify institutionalised behaviours.⁷⁹ Defiance often is dyadic, patient towards their clinicians, but it can also target authorities including commissioners of healthcare, when perceiving the latter's values as burdening and hampering one's recovery.

4.1.6 The place of virtues within flourishing

Being virtuous is only one of the key ingredients to one's flourishing in life; other factors include those around health, relationships and financial security. Some of these other factors can be out of one's reach but cultivating virtues is one factor that is more often achievable, regardless of one's position in life. In efforts to achieving flourishing, one then strives for upholding and developing one's virtues. Virtue use is not always successful; burdened virtues arise as the product of norms that prevent

⁷⁸ Potter. *Ibid*, pg. 25. This highlights that norms are the mechanism through which the dominant group maintains power, including through social roles, authority, education, media and other methods.

⁷⁹ W.S. Chow & S. Priebe. Understanding Psychiatric Institutionalization: a Conceptual Review. *BMC Psychiatry*, (2013), 13:169. Lack of defiance and resistance may also indicate institutionalized behaviours, more common in chronic mental illness and intellectual disabilities.

one from moving out of their lowly positions. Such burdened virtues can lead to moral damage in various ways, not least in that the oppressed person's views get distorted as they adapt to relations of domination and subordination.⁸⁰ Burdened virtues in patients may appear helpful for the running of psychiatric hospitals, but they become detrimental to the experience of the patient exhibiting virtues, hampering patient clinical improvement.

Defiance can provide reasons on how to act. When MacIntyre asks; 'What is the good for me?', defiance serves to help in how one's life, as understood by the unity disclosed in its narrative, might best be brought to completion.⁸¹ Norms organise societal beliefs and values in a coherent logical manner that reproduce the dominant voice's agenda, whilst marginalising less coherent perceptions.⁸² For Hilde Lindemann Nelson, defiance and resistance through counter-stories such as those of psychiatric experts by experience, can start to help the marginalised reclaim their agency and identity, triggering those responsible for service delivery to take notice. The consequences to defiance and resistance however tend to favour the privileged rather than the oppressed. The use

⁸⁰ Tessman. *ibid.*

⁸¹ Alasdair MacIntyre. *Ethics in the Conflicts of Modernity*. Cambridge University Press, 2016. For MacIntyre, we generally become aware of the narrative structure of our lives infrequently and in either of two ways: when we reflect upon how we can make ourselves intelligible to others by telling them the relevant parts of our life story, or when we have particular reason to ask 'How has my life gone so far? How must I act if it is to go well in the future?' What occasions the asking of these questions is a need to make critical choices at points in our lives in which alternative futures open up. It entails one to reflect on their history, knowledge, one's abilities and limitations, about the errors one is prone to make and about the resources one has available to them.

⁸² Hilde Lindemann Nelson. *Damaged Identities, Narrative Repair*. Cornell University Press, 2001. Here Nelson in expounding on master narratives expands on the view that one's own identity is in part formed by society that places individuals within their own personal narratives, which can include harmful narratives towards the self. Furthermore master narratives can directly harm individuals as they shape how society treats individuals and how they see themselves.

of defiance, including that through experts by experience, requires use to remain moderated, as one evaluates potential consequences in line with one's flourishing needs.

4.1.7 On the ontology of excellent reasoning and oppression

For Aristotle, what defines the human species is the ability to reason; excellent reasoning is ontological and can be achieved through the use of the virtues. Virtues are not relative or subjective but nevertheless require consideration of when and the mean of use within specific contexts. Oppression is also ontological; stigma and assumptions about mental illness are socially and psychologically created through the norms of existence.⁸³ Essences that describe mental wellbeing, such as the pathological versus the functional, offer a binary nature to being. However, phenomenologists ever since Karl Jaspers have tended to push back on the notion of such binaries in mental health, since human experiences are both inherently fluid and difficult to label.⁸⁴

What one considers and is attentive to, depends on their previous knowledge and needs, asserts Iris Murdoch.⁸⁵ Most of what one experiences resides in the subconscious; this may lead one to consider

⁸³ How we interpret the world we live in influences our moral reasoning and our use of the virtues. It is also arguably the case that the use of virtues allows for reflective deliberation that then allows one to infer the world more correctly; one therefore needs a state of relative cognitive wellbeing.

⁸⁴ The binary notion of psychiatry is *categorical*; one either has a condition that meets DSM or ICD criteria, or not. Here, conditions are recognized through objective rather than subjective criteria and one aims at diagnostic clarity so as to then prescribe specific treatment approaches. On the other hand, phenomenology considers one to be on a dimension of a lived, subjective experience. Phenomenology seen in this sense can help deepen the understanding of a diagnosis for the individual patient, including the insights that patients report whilst living with a condition.

⁸⁵ Iris Murdoch. *The Sovereignty of Good*. Routledge, 1970. For Murdoch, one's understanding is always shaped by what one has already learned, experienced or assumed. We can never be objective in the way we experience the world. Moral progress therefore often occurs through seeing things differently, such as following further reflection.

choices they make, including about acting defiantly, as being based on tacit knowledge. Virtue ethics nevertheless requires that one reflects after all events, including acts of defiance during provision of healthcare, so as to be able to rationally explain how and why one acted in that particular way. Such a possibility may not always be possible during an episode of mental illness; such as for instance, when the patient's ipseity and self-presence, through having disturbances in spatio-temporal structuring, are affected in psychotic disorders.⁸⁶ Nevertheless, defiance remains a mechanism for patients and their clinicians to assert one's self-respect, and to communicate to others one's moral worth.⁸⁷

4.1.8 On virtues, capabilities and objectivity

For Martha Nussbaum, flourishing is linked with the external conditions that make it possible. This is through the theory of the ten basic essential *capabilities*, which all humans ought to be guaranteed.⁸⁸ Defiance is justified when such capabilities are thwarted. Capabilities and virtues are

⁸⁶ Louis Sass. 'The Life-World of Persons with Schizophrenia'. In *The Oxford Handbook of Phenomenological Psychopathology*. Edited by G. Stanghellini et al. Oxford University Press, 2019: pp. 597-618.

⁸⁷ D. Fiorillo et al. 'Social Participation and Self-Rated Psychological Health: A Longitudinal Study on BHPS.' *SSM Population Health*, 2017. Subjective well-being is known to be linked with one's social contact network. This has various consequences including on the 'economics of happiness'. This study is based on the British Household Panel Survey and affirms how being an active member within social groups offers both psychological and economic benefits. Feeling connected and valued leads to subjective well-being.

⁸⁸ Martha Nussbaum. *Frontiers of Justice: Disability, Nationality, Species Membership*. Cambridge University Press, 2003. Nussbaum, in contrast with Amartya Sen, gives a more specific prescriptive list of how a good quality of life can be measured. Nussbaum's list includes capabilities of: Life without premature death; Bodily Health including freedom to reproduce; Bodily Integrity including freedom from abuse and assault; Senses, Imagination and Thought which links to one's freedom of expression and education; Emotions which includes ability to form attachments and having one's emotional development not curbed by anxieties; Practical Reason which encompasses being able to engage in critical reflection and planning one's own life; Affiliation which facilitates social interactions and allows one to be treated with dignity; Other Species that allows one to live with concern for all the world of nature; Play which allows one recreational time; and Control over One's Environment which allows for political choice and freedom, property rights and economic participation.

related in that cultured virtues will allow one to realise capabilities.⁸⁹ For Tessman, current modern society only allows *non ideal flourishing* in contrast to the Aristotelean ideal flourishing to which Nussbaum ties her arguments; the virtues are important guides with no guarantee of eventual flourishing. Thence virtues are considered burdened even while their implementation can help enhance one's self worth.⁹⁰ Flourishing is best conceived as choosing the life narrative one wishes for themselves without having regrets about it, since the virtues help rationalise how and why this life remains meaningful.

Individual knowledge is embodied and limited; in addition to one's individual knowledge, one utilises unlocated external knowledge that helps them perceive meaning through interactions with others. This is through the webs of connections that provide for shared conversations, claims Donna Harraway.⁹¹ As a result, knowledge always remains partial; one is required to appreciate the limitations of what they know and how this knowledge influences why they come to adopt certain perspectives. Dominant knowers in the mental health sphere, including clinicians, need

⁸⁹ As one strives to improve their lives in a fast changing world, one has to face *ethical costs of mobility*; one needs to reflect on costs to their stability when one wishes and acts for change claims Jennifer Morton. (Jennifer M. Morton. 'Towards an Ecological Theory of the Norms of Practical Deliberation.' *European Journal of Philosophy*, 2010.) Whilst stability facilitates flourishing and success, for those from disadvantageous backgrounds such as those growing up in poverty or suffering from past abuse that both predispose to increased rates of mental illness, defiant acts will often entail trade-offs that can undermine their stability. Norms of deliberation and practical reasoning depend on one's environment and the needs of others within one's environment, thence giving others, such as family carers, an ethical standing.

⁹⁰ Tessman. *ibid.* Tessman is here considering what flourishing can look like in conditions of injustice. She is being critical of Nussbaum's capabilities in that these are perceived to be conflicting between themselves and that it is practically impossible for anyone to have access to all of them concurrently. Flourishing is a relative term and it is often a costly, partial and conflicted state.

⁹¹ Donna Harraway. 'Situated knowledges: The science question in feminism and the privilege of partial perspective.' *Feminist Studies*, 1988. All knowledge comes from a specific perspective such that there cannot be the view from nowhere that captures all truth.

to critically evaluate their epistemes, schemas, stereotypes and assumptions. Objectivity is aided through ongoing critiques, defiance and negotiations, in a process that identifies dominant and suppressed viewpoints; emphasis need to be made so as to ensure that patient and, when appropriate, their carer's viewpoints are also sought. According to Maria Lugones, one needs to span across the different perspectives, trying to understand others as themselves, in a world with different groups and cultures. Mental health professionals are required to remain open to learn from, adapt to, and connect with their patient's different perspectives.⁹²

In this section, the psychiatric episteme was defined as part of the cultural norm, facilitating predictability and safety within the population. Norms and epistemes change over time; defiance is one of the means whereby one can influence and take personal responsibility for their care, as well as influence norm change. In this sense, defiance can serve as a virtue for the individual patient and helps reduce general risks of epistemic injustice in psychiatry. I now proceed to further explore the relationship between virtue ethics and phenomenology in the care delivery process.

⁹² Maria Lugones. 'Playfulness, "World"-Travelling, and Loving Perception.' *Hypatia*, 1987. 'World travelling' has to do with actual experience and requires one to engage in activities where one will experience what others experience. One has to deal with people not with theoretical constructs. One gets to appreciate genuine differences, of which alternative hermeneutical resources can be an example.

4.2.0 Virtue Ethics and Phenomenological Care

A six stepped framework that serves as a normative approach towards the delivery of better quality psychiatric care is here outlined. This is used as the basis to discuss the ethical implications of each step in care delivery.

1. An individual person perceives that something is not right in how they experience the world, leading to suffering.
2. The person reflects and holds discussions with others, who acknowledge that there could be a condition that requires help.
3. The person as a patient seeks help from a healthcare professional. The professional is likely to utilise perfunctory systems that may objectify the patient and that do not give much attention to their life narrative, or as to how symptoms are embodied and experienced. Nonetheless, a diagnosis gets made, often with the help of AI processes.
4. The clinician advocates a treatment program, based on a learnt stereotypical outline of an illness, following their previous training. This treatment may work to the expected degree.
5. Treatment is sometimes not effective, in which case the clinician explores whether the use of the stereotype was justified. A deeper exploration of symptoms within a diagnostic schedule such as the DSM-5 is undertaken. Consideration may be given to the co-production of care.
6. There may remain questions about the diagnostic and treatment formulation. Further phenomenological exploration helps allow such patients achieve epistemic justice and a possibility to co-produce meaningful therapeutic interventions.

4.2.1 Exploring Step 1

This section asks the question of why one comes to feel distressed, exploring how symptoms are created, as well as their meaning. Although mental illness is an altered way of being in the world, this should not define the whole person.⁹³ Mental illness does indeed affect all one's experiences of reality including time, space and emotions; one becomes prone to not being understood and at risk of epistemic injustice. Suffering and distress results from threats to one's meaning in life, for instance due to an inability to carry out a social role. Struggle may result in a perceived need to readjust one's life narrative as they pursue excellence. Some patients suffer since they may not be able to perform a job or have lost the ability to do activities where they previously expressed their drives and passions. Most significantly, the loss of sociability in mental illness often leads to loneliness and despair. When illness impinges on one's life narrative, one rationalises and considers the adding an illness narrative.

For M. Cameron Hay, the interpretation of sensations is always tentative, conditional of further cultural information regarding whether the sensation should be construed as a symptom. 'A sensation is embodied; it is felt experience. By contrast a symptom is a constructed and socially informed cognitive interpretation that indexes but is not itself an embodied sensation.'⁹⁴ Such dichotomy between sensation and symptom however dissolves for the individual patient. 'Sensorial

⁹³ Thomas Fuchs et al.. 'Embodied Affectivity: on Moving and Being Moved.' *Frontiers in Psychology*, 2014.

⁹⁴ M.C. Hay. 'Reading Sensations: Understanding the Process of Distinguishing 'Fine' from 'Sick'.' *Transcultural Psychiatry*, 2008. For Hay, the interpretation of sensations is always tentative, conditional of further cultural information regarding whether the sensation should be construed as a symptom.

anthropology explores how sensations are experienced phenomenologically, interpreted culturally and responded to socially,' reflects Mark Nichter.⁹⁵ Illness as influenced by one's cultural background leads to fears, changed behaviours, impacts on social relationships, and economic hardships that then lead to health seeking behaviours. Meaning stands within a moral landscape; here, being a good citizen means that one looks after their health and to not misuse healthcare resources. Furthermore, one's social positioning can lead to delays in one's health seeking behaviours.

4.2.2 Exploring Step 2

I will now explore how one begins to communicate their distress. The expression of feelings, wishes and thinking is invariably present in one's gestures, voice intonations, breathing, skin perspiration, facial expressions as well as one's verbal testimony. Through empathy, one gains an understanding of the other and can immerse in experiencing the other at that moment in time. Empathy thus represents an *other-understanding*;⁹⁶ however, this does not mean that the perceiver actually lives through the lived experience of the perceived. Others always surpass our grasp, but as we encounter others in a particular situation in this world, our way of being together in such shared situations brings us meaning.

⁹⁵ Mark Nichter. 'Coming to Our Senses: Appreciating the Sensorial in Medical Anthropology.' *Transcultural Psychiatry*, 2008. Sensations are amplified or suppressed in accordance to cultural values, work demands and health concerns. Somatic modes of attention are articulated to others through socialization.

⁹⁶ Edmund Husserl. *Cartesian Meditations: An Introduction to Phenomenology*. Martinus Nijhoff, 1977.

The perceiver accepts the experiencer's account rather than undermines the person's experiences by such attitudes as 'romanticising' illness or by adopting naive attitudes.⁹⁷ Empathy however risks causing epistemic injustice when the perceiver projects their own interpretation as being that of the perceived, whilst increasing risks of the patient being objectified.

4.2.3 Exploring Step 3

Illness experience is transformed to a symptom of disease, whereby clusters of symptoms point towards a particular diagnosis. Symptoms therefore serve a communicative function for experiences, but they cannot convey all one's bodily and lived experiences. Psychiatry fuses phenomenology, the structure of experiences, with hermeneutics, the interpretation of meaning. Sometimes, interpretation offers excess meaning whereby what we are presented with does not fit with the stereotypical guess the clinician expected; clinicians get tempted to fit square pegs into round holes. This will then entail further checking of interpretations in line with the updated expectations, in an ever reiterative process. There remains the risk that what is intelligible becomes all that there is to understand, obscuring experiences that do not fit in the model of disease.⁹⁸ Psychiatrists need training so that testimonial smothering becomes less likely and to also develop what Alistair Wardrope termed as *epistemic humility*, a better understanding

⁹⁷ Jake Jackson. 'Patronizing Depression: Epistemic Injustice, Stigmatizing Attitudes and the Need for Empathy.' *Journal of Social Philosophy*, 2017.

⁹⁸ E. Fabris & K. Aubrecht. 'Chemical Constraint: Experiences of Psychiatric Coercion, Restraint and Detention as Carceratory Techniques.' In *Disability Incarcerated: Imprisonment and Disability in United States and Canada*. Ed. L. Ben-Moshe et al.. Palgrave Macmillan, 2014.

of one's knowledge and fallibility.⁹⁹ Clinicians need to suspend an assumption that symptoms capture the totality of experiences.

Robert Sokolowski elaborated on the concept that in the psychiatric episteme, the role of the patient includes accepting that professionals offer their understanding, as enhanced by the clinician's expertise and knowledge, 'as an extension to the patient's minds.' Within such shared knowledge, joint formulations can be produced towards addressing the patient's symptom.¹⁰⁰ However, due to time pressures, psychiatrists remain at risk of *objectifying* their patients in the sense of using patients solely as sources of verbal or observational information, valuing them only for the information they hold and provide.¹⁰¹ Objectification therefore becomes more likely when patients are deemed to lack insight, where objectification can however serve to protect the clinician from impacts of any violent statements such patients may make.

Often, medicalisation does not obscure but rather illuminates individual experiences. The authority of psychiatry produces a *medicalised subjectivity*, transforming and constraining the agent's self-understanding whilst prescribing reasons that are deemed legitimate on how one lives their life. For Wardrope, biomedical models *save the phenomena*; they describe effectively the salient clinical pathological

⁹⁹ Alistair Wardrope. 'Medicalization and Epistemic Injustice.' *Medicine, Health Care and Philosophy*, 2015.

¹⁰⁰ Robert Sokolowski. 'The Fiduciary Relationship and the Nature of Professions.' In *Ethics, Trust and Professions: Philosophical and Cultural Aspects*. Ed by E.D. Pellegrino et al.. Georgetown University Press, 1991.

¹⁰¹ Edward Craig. *Knowledge and the State of Nature*. Clarendon Press, 1990.

features and then prove fruitful in guiding treatment.¹⁰² The biomedical model is not meant to provide an adequate description of all the phenomenon's dimensions but only the most salient ones linked to the health worker's practice. The biomedical model needs to be complemented by social and other models so as not to contribute to epistemic injustice. Reassuringly, medicalisation through treatment can also render one's existence as more authentic.

4.2.4 Exploring Step 4

Fricker elaborates on the virtues of testimonial and hermeneutical *justice*; this latter virtue is always corrective. The hearer who is immune to the interlocutor's efforts that remain hampered, is failing in giving epistemic justice.¹⁰³ This is not an issue with the speaker; it is an issue about the relations between the perceiver and the perceived; the clinician must be aware of the differences in social identity between them and their patients and on how this can impact intelligibility. Social hierarchies may also affect what the speaker says and how the speaker says it. The clinician being thus sensitive, allows for corrections to an initial credulity judgement. An orientation to truth must allow consideration for more than one interpretation on the truth.

¹⁰² Wardrope. *ibid.* Symptoms of illness are not just there but are interpreted and constructed. The clinician encounters the perceiver who is experiencing the lived illness experience, from which they construct the symptom. The symptom preserves what matters to the patient, making it useful as an explanation, in communication as well as in diagnosis and treatment. The clinician can miss the pattern and miss symptom diagnosis or they can over-diagnose the phenomenon, forcing the lived experience into an existing biomedical map that does not match the patient experience.

¹⁰³ Fricker. *ibid.* Pgs. 169-175. Accordingly, hermeneutical justice is then the; 'alertness or sensitivity to the possibility that the difficulty one's interlocutor is having as she tries to render something communicatively intelligible is due not to its being a nonsense or her being a fool, but rather to some sort of gap in collective hermeneutical resources.'

According to Fricker, where there is enough time, the virtuous hearer must use the most appropriate language to try ‘to generate a more inclusive hermeneutical microclimate...’ This can involve listening to what is not being said through epistemic silencing, as well as trying to check understandings, whilst holding confidentiality, with others who share the same social identity of the speaker. If the situation is a psychiatric emergency, such as when the patient risks severe harm to themselves, there will be no time ‘to listen through.’ The virtue of hermeneutic justice then may imply that one reserves their judgement, ‘so that the hearer keeps an open mind as to credibility.’ For the virtue of hermeneutical justice, testimonial sensibility has to be sufficiently educated by individual and collective experiences. For Fricker, such intellectual and ethical virtue then aims to ‘neutralize the impact of structural identity prejudice on one’s credibility judgement.’

4.2.5 Exploring Step 5

Jose Medina tasks us to continually strive against epistemic injustice which is otherwise endemic; clinicians must counter such risks through the use of virtues including those of humility, open mindedness and diligent curiosity.¹⁰⁴ Such virtues also help combat stigma. Empathy entails that one remains humble whilst recognising that the perceiver cannot know the other’s experiences directly. Empathy is an ongoing diligence task; one remains open minded to the other’s testimony and differences.¹⁰⁵ Empathy requires accepting differences, making no attempts to eliminate such differences; clinicians must refrain from

¹⁰⁴ Jose Medina. *The Epistemology of Resistance: Gender and Racial Oppression, epistemic Injustice, and Resistant Imaginations*. Oxford University Press, 2013.

¹⁰⁵ Jackson. *ibid*.

comparing the patient's experiences to their personal experiences or to those of other patients.

Empathy is not the same as giving uptake since giving uptake takes place within a therapeutic relationship and aims at countering the patient silencing, whilst empathy can take place in all relationships between the perceived and the perceiver. Epistemic injustice and credibility reduction in mental healthcare can however be justifiable in that they can on occasion, afford patients moral luck, reminds us Eisuke Sakakibara.¹⁰⁶ The psychiatrist can here be justified in not accepting experiential reports made by perceivers who are irrational due to severe mental disorder. Ticking off symptoms within categorical classifications here serves to assign adequate treatment and clinical outcomes, especially when there are attempts at the co-production of the treatment plans.¹⁰⁷

4.2.6 Exploring Step 6

For Potter, and following on from J. L. Austin's description of illocutionary acts, aside from serving a descriptive act, language serves as a form of action through giving uptake; the patient is enabled to build a trusting rapport with the clinician.¹⁰⁸ When giving uptake occurs, trust enables

¹⁰⁶ Eisuke Sakakibara. 'Epistemic Injustice in the Therapeutic Relationship in Psychiatry.' *Theoretical Medicine and Bioethics*, 2023.

¹⁰⁷ E. Harcourt & D. Crepaz-Keay. 'Co-Production is Good, but Other Things are Good Too.' *Royal Institute of Philosophy Supplement*, 2023. This provides examples various types of co-productions, not just the clinical ones. Aside from co-production, there are other progressive innovations in mental healthcare, including promoting social inclusion, expert by experience led initiatives and the reduction of stigma through enhancing voluntary roles through regular links with local industries and groups in the community.

¹⁰⁸ J.L. Austin. *How to do Things with Words*. Ed. By J.D. Urmson. Echo Point Books & Media, 2023. An illocutionary act implies an action when one says something, such as a promise or a warning. Uptake occurs only if the hearer grasps the act being performed; by giving uptake, the clinician grasps the patients' phenomenological experiences by the statements and reiterations they make. The patient must recognise that the clinician has given uptake to their narrative.

the patient to take on board insights provided by the clinician, including knowledge that allows the patient to better understand their experience of the world. Giving uptake involves an appreciation of the patient's narrative as influenced by context and social power relations that can propagate epistemic injustice. To seek epistemic justice is itself an ethical virtue.

According to Gaile Pohlhaus, knowers need to develop particular virtues that facilitate relations with one another, as well as an ability to perceive and respond to one another in particular ways, as society requires pooling and sharing of information for survival. One has to recognise the other, who always experiences the world differently; this poses a number of caveats, including that recognition is dependent on the social distance between hearer and speaker. It also gives rise to issues of vulnerability that occur when one recognises the other; recognition can serve as power that the hearer has over the speaker.¹⁰⁹ Pohlhaus also considers the value of pooling of information, such as from other Multi-Disciplinary Team members in a clinical setting, whereby others offer 'multiple loci of experience,' that can be utilised in reducing epistemic injustice.

One must bracket stereotypes during an empathic encounter, where otherwise stereotyping offers us 'an assumption' of what the other is feeling. Conversation needs to remain an open source of further confirmation in such dyadic interactions.¹¹⁰ Our experiencing of the

¹⁰⁹ Gaile Pohlhaus Jr. 'Discerning the Primary Epistemic harm in Cases of Testimonial Injustice.' *Social Epistemology*, 2014.

¹¹⁰ Dan Zahavi. *Self and Other: Exploring Subjectivity, Empathy and Shame*. Oxford University Press, 2014.

other continues to change over time and across different situations; we cannot rely on memorised classifications of others and their differences from us. In clinical encounters, one needs rely on ongoing empathic experiences. Clinicians need to be able to spend adequate time with the patients rather than using the allocated time to record and defend any action or deduction that they made. Artificial Intelligence or other algorithmic symptom ticking exercises can only afford emulated uptake and empathy towards the patient. On the other hand, AI can prove helpful in elucidating certain biases inherently leading to hermeneutical injustices, such as through aggregating marginalised narratives.

4.3.0 On Illness and Life Narratives

For Arthur Frank, when one becomes ill and makes sense of what is happening, one creates illness narratives. Mental illness can present as *chaos* or perhaps as *quest* narratives, where the latter leads to new insights and purpose; the former leaves the person without a structured story when struggling to reconstruct their identity. Narratives of mental illness aim at making suffering understandable, which in turn allows one to regain a sense of control; however, narrative making in psychiatry runs various risks, including that the clinicians may inadvertently replace the patient's meaning making narrative with the stereotypical interpretation that the clinician holds. Narratives patients hold may however help resist stigma through the reframing of the illness as a meaningful life

experience; less adaptively however, narratives can also leave one feeling as a failure, thus reinforcing the stigma around mental illness.¹¹¹

As perceived by MacIntyre, narratives seek to make sense of the structure of human life, whereby everything one does maintains the continuity of a purposeful life story, within which morality is key. According to Frank, the illness narrative only arises following a disruption, such that a new story emerges to reconstruct one's experience of disease; it thus allows for one having incomplete and disjointed narratives. Both emphasise that we find meaning through storytelling and thus our identity is not fixed but flexes with our narrative. To really understand a person, one needs to understand their personal narrative, which is influenced by how ongoing raw worldly experiences appear to that individual's consciousness. Thence narratives are ontological in MacIntyre's perspective. Narratives offer belief on a series of phenomenological experiences across time, supporting what is anticipated and what one can recollect in the memory of past events that fit the narrative.

Narratives are there to be recounted to ourselves and to others. Through such narrations, the meanings of our narratives can be validated and thus our identity can become recognised by another. Accordingly, the experience is given interpretation within social contexts. For Paul Ricoeur, identity itself is ontologically narrative, whereby human lives are

¹¹¹ Arthur W. Frank. *The Wounded Story Teller: Body, Illness and Ethics*. 2nd Edition. University of Chicago Press, 2013. Chaos narratives tend to be formulated in severe mental illness as an attempt to overcome suffering. However, such narratives tend to be less adapting to what is expected in social life and thus are poorly understood by others, including the treating clinicians.

stories that then define our identity, our actions and our lives. Live's meaning is ongoingly being construed by the individual within social contexts. We live our lives as narratives that get socially validated.¹¹²

4.4.0 Conclusion

With ever increasing rates of mental illness as driven by societal attitudes and newly identified conditions, psychiatry stands at a crossroad. Requests for prescribed treatments, pharmacological or otherwise, are not always directed towards a fuller understanding of suffering that one seeks to alleviate. Some treatments and diagnoses appear to be driven by social and marketing influences. In this setting, it is perhaps no surprise that clinicians have less time to offer patients; diagnoses are at times made based on questionnaire filling and algorithm checking, with little emphasis on building rapport, offering empathy, time or uptake in the process. This practice purportedly serves so that clinicians can achieve better clinical effectiveness and cost savings. Adopting this approach across the board in mental healthcare comes to the detriment of people who suffer from chronic and more serious mental illness. The latter need to be afforded time and confirmation in building illness narratives and often, in rebuilding their lives.

Giving uptake entails a virtuous stance on belief that fosters dialogue; this has the added advantage that it enhances the clinician's self-knowledge of the world and of themselves. Not giving uptake is a moral choice of the clinician as listener, whilst giving uptake is a virtue clinicians develop

¹¹² Paul Ricoeur. *Oneself as another*. University of Chicago Press, 1992.

as they learn to appreciate the patient's phenomenological experiences. Psychiatric care can strengthen the patient's virtues and diminish vices they may have, through gaining insights into moral damage perpetuated through social structures. It is now time for psychiatry to decouple itself from the current diagnostic and pro-marketing bandwagon and instead take the more phenomenological turn, through the use of ethical virtues developed by better educated clinicians, patients and the public at large. Good psychiatric care requires judgement and reflection rather than relying solely on technical expertise.

Chapter 5: Final Conclusion

In this dissertation it was argued how ethical virtues are essential for the delivery of psychiatric care. This discussion explored how ethical virtues help by adding meaning to the patient's life, reducing epistemic injustice throughout the care process. Phenomenological psychopathology can help clinicians understand the patient's life as lived through the illness, including the patient's perception of their own personal value. Distress, as communicated through help seeking behaviours, can lead to the identification of clinical symptoms and to the provision of care. Care facilitates that one makes adaptive changes to their life narrative. Changes to how patients experience their illness are informed by the virtues demonstrated and held by the treating clinicians. Experiencing care in this way, helps correct negative cognitions that serve as vices and to add new virtues that help to fashion authentic life narratives and that contribute to a meaningful future life.

This discussion further explores how ethical virtues including empathy, help clinicians build rapport with their patients. Clinicians are urged to make use of other virtues, including those described by Potter. The virtue of defiance can serve the patient to better understand what treatment and care will offer them; it also helps in the process that can overcome hermeneutical injustice. The virtue of giving uptake serves patients to trust clinicians who experience patients as equal beings.

Some of the challenges facing psychiatric practice were outlined; a six step normative approach that help to identify those who require more

in-depth phenomenologically informed care was also described. The latter helps improve the quality of care delivery whilst reducing waiting times. The concept of epistemic injustice as developed by Fricker was analysed, outlining how the virtuous clinician will be able to make a number of adjustments in the way they approach clinical interactions, reducing the risk of such injustices. Such approaches will require that clinicians reflect on their clinical practice and on their virtue use, making ongoing adjustments as to how they interact with individual patients, whilst continuously reevaluating the impacts of clinical interactions on the patient's interpretation of their experiences.

The concept of narrative identity was developed to help outline how changes to the patient's life narratives can have a positive effect on how patients continue to experience their lives. Virtuous care delivery serves a critical role in ensuring that such narrative changes represent realistic patient goals, supporting a flourishing existence.

The dissertation explores ways to facilitate the humane delivery of care in the face of commissioning demands for a quicker turnover of care episodes. The role and the need for empathy in care processes, including through the use of phenomenological inquiry was evaluated. Clinicians are urged to fight alongside commissioners of healthcare in efforts to saving services that offer humane and epistemically informed care for those with severe and chronic mental disease. It is stipulated that such models of care can facilitate better recruitment and retention of staff, whilst reducing staff burnout. Findings in this dissertation support the need for patients and the general public to be better informed about the

impacts of mental illness and of the need to better respect and support each other within society. It was discussed how such educational needs could have an initial focus through teaching ethical virtues to mental health clinicians.

Various implications arise from this present work, including that clinical training and practice within psychiatric care requires to be more orientated to the development of ethical virtues and toward reflections as to how clinicians practice. It highlighted why there is a need for co-production of care and how this helps set realistic goals towards recovery; this also extends to the use of experts by experience in service modelling and evaluation. Tension will inevitably remain between the pressures to deliver more care to more people, and the need to reduce or eliminate epistemic injustices within mental healthcare delivery. It was proposed how the outlined six stepped normative approach, which tailors interventions in such a way that when initial algorithmic and categorical diagnostic systems fail at improving the patient's experiences of illness, the use of extra resources can be justified

In developing this dissertation, consideration was given to the work of MacIntyre who never directly considered the impact on ethical virtues through the use of AI in clinical care. Had he considered this, he would likely have explored how AI could positively influence one's development of practical wisdom and the other virtues: Would AI make humans more inquisitive about each other's welfare, or would it make humans neglect each other, as their need for information is increasingly delivered through algorithms, leading to moral disengagement and the ethical disregard of

others? It is still unclear how AI influences one to choose between building a life of eudaimonia rather than a hedonistic life. It was discussed how for Macintyre, human healing experiences can only be achieved because of our mutual interdependencies. Without such interdependency, human flourishing is unlikely to be achieved. What is achieved instead are simulacra of flourishing, that hold onto accounts of unrealistic life outcomes, potentially suppressing the inevitability of illness and distress in life. It was argued that AI will potentially produce more beneficial effects on the attainment of certain external goods rather than internal goods, including those of one's moral development.

In constructing the analytical framework of this dissertation, it was ascertained that mental healthcare is not just the identification and the management of symptoms. It is an ethical encounter between clinicians and vulnerable individuals who feel distressed, as they are attempting to preserve meaning in their lives. Such individuals seek guidance and support to help regain their agency and their selfhood through the recovery process. In the face of ever-increasing demands for care, it was argued that clinicians need to avoid falling into the trap of considering patients as their symptoms, diagnosis and as treatment algorithms; diagnoses that classify patients according to their disabilities do not support one's dignified inclusion into society. This is of particular significance to those who endure the effects of disabling long-term illness.

Empathy serves both as a clinical virtue that allows clinicians to accurately grasp the patient's experience of illness, and as an ethical

virtue that helps one to understand how suffering impinges on the patient's life. This dissertation has demonstrated that amongst the virtues, empathy helps to elucidate the patient's vulnerabilities to epistemic injustices. It aids clinicians to identify the more salient interpretations that serve to offer meaning to the patient's experiences. It is evident that development of ethical virtues functions as a driver for change and the acceptance of therapeutic interventions. Empathy can furthermore help clinicians perceive the world differently, thus reducing risks of epistemic injustice in the therapeutic care process. This dissertation ultimately demonstrates that ethical virtues are not optional extras but are the very foundation for effective psychiatric care. Their centrality must be recognised and acknowledged in the delivery of efficient and just mental healthcare.

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