Structural Epistemic and Ontic Injustice in Contemporary Regimes of Mental Health Governance – how to advance a reconfiguration of the "Normal"

Abstract

This essay argues that contemporary psychiatry constitutes a site of structural epistemic and ontic injustice. Drawing on Miranda Fricker's account of epistemic injustice, Katharine Jenkins' concepts of ontic injustice and ontic oppression, and Iris Marion Young's theory of structural oppression, the essay shows that psychiatric patients are systematically disadvantaged as knowers, social agents, and participants in public life.

Psychiatric practices produce enduring credibility deficits, undermine patients' epistemic agency, and constitute them as members of stigmatized social kinds under unjust conditions. These harms are not reducible to individual prejudice or professional failure but are embedded in institutional power asymmetries, diagnostic authority, and the possibility of coercion.

The essay further argues that psychiatry does not merely respond to social marginalization and distress but can actively produce exclusion, dependency, and powerlessness through practices such as involuntary treatment, diagnostic overshadowing, cultural imperialism, and structural violence. Against this background, the essay asks what pathways exist toward a more epistemically just model of psychiatric care and how the normative standards governing psychiatric practice might be redefined.

In response, the essay introduces the concept of a "new normal" in psychiatry: a normative reorientation that shifts authority away from biomedical dominance toward epistemic partnership, pluralistic understandings of distress, and the recognition of psychiatric patients as credible epistemic agents.

Drawing on emancipatory movements such as Mad Studies, survivor research, peer support, culturally sensitive psychiatry, and the normative framework of the UN Convention on the Rights of Persons with Disabilities, the essay outlines key elements of an epistemically just psychiatric model. It concludes that achieving justice in psychiatry requires not incremental reform but a fundamental transformation of its epistemic, ontological, and institutional foundations.

Introduction

Despite growing awareness of epistemic injustice and calls for reform, psychiatric practice has not substantially improved in addressing the structural injustices experienced by patients. Institutional power imbalances, coercive practices, and biomedical dominance persist, continuing to undermine patients' credibility, autonomy, and well-being. This essay takes the position that without a fundamental normative and structural transformation—a redefinition of psychiatric knowledge, authority, and relational dynamics—epistemic and ontic injustices in psychiatry will endure. Incremental ethical training or procedural reforms alone cannot dismantle the embedded patterns of marginalization and exclusion.

Illustrative Case Examples

- Diagnostic Overshadowing: A patient with a psychiatric diagnosis repeatedly reports symptoms of physical illness (e.g., persistent pain, fatigue) which are dismissed as psychosomatic or manifestations of their mental disorder. As a result, serious conditions such as cancer or infections remain undiagnosed for years.
- Coercive Treatment: An individual subjected to involuntary hospitalization and forced medication experiences severe side effects and psychological trauma. Their complaints and refusal of treatment are interpreted as lack of insight, further justifying coercion and undermining their agency.
- Marginalization through Institutionalization: Long-term residents of forensic psychiatric facilities describe their living conditions as "ghettoization," isolated from social life, with little access to employment, education, or meaningful social participation, exacerbating social exclusion rather than alleviating distress.

These cases exemplify how psychiatric systems continue to produce epistemic harm and ontic oppression, underscoring the urgency for the new normative framework proposed in this essay.

Research Questions

This essay is guided by the following research questions:

What forms of epistemic and ontic injustice are structurally produced within contemporary psychiatric systems?

In what ways do psychiatric practices constitute forms of structural oppression, rather than merely responding to individual pathology?

What pathways exist toward a more epistemically just model of psychiatric care?

How could the normative standards of psychiatric practice be redefined, and what might count as a "new normal" in psychiatry?

Are there any attempts for compensation in case of misdiagnosis or mistreatments?

Psychiatry as a Site of Epistemic and Ontic Injustice

Following Miranda Fricker, epistemic injustice occurs when individuals are wronged specifically in their capacity as knowers. Psychiatry provides a paradigmatic case. Patients with psychiatric diagnoses are frequently treated as less rational, less reliable, and less competent than other patients.

Their testimony is subject to a systematic credibility deficit: once labeled “mentally ill,” their statements are often discounted, reinterpreted, or dismissed altogether.

This manifests as testimonial injustice. Patients’ reports of side effects, coercion, or mistreatment are frequently interpreted as symptoms, expressions of lack of insight, or manifestations of pathology. Disagreement is medicalized; resistance becomes “non-compliance.” As a result, psychiatric patients are denied recognition as credible witnesses of their own experiences and realities.

In addition, psychiatry generates hermeneutical injustice. There is a significant lack of shared interpretive resources to make psychiatric experiences—especially experiences of coercion, restraint, or institutional violence—intelligible. Only a narrow and medicalized vocabulary is institutionally recognized, while patients’ own explanatory frameworks are overridden by diagnostic categories. Even when individuals can articulate their experiences, they are often not properly understood, because psychiatric knowledge sets the terms of intelligibility.

These epistemic injustices are not incidental but structurally produced. Institutional power asymmetries, the authority of diagnostic classifications, and the possibility of coercion ensure that medical interpretations are privileged over patients’ accounts. Psychiatric patients are thus systematically disadvantaged as knowers, reasoners, and questioners.

Taken together, epistemic injustice (Fricker), ontic injustice and oppression (Jenkins), and structural oppression (Young) reveal psychiatry as a social system that systematically undermines patients’ epistemic agency, autonomy, and social standing. These injustices are not anomalies but features of an institutional order grounded in diagnostic authority, coercive power, and biomedical normativity. Katharine Jenkins’ concept of ontic injustice deepens this analysis by shifting attention from epistemic exchange to social being itself. Ontic injustice occurs when individuals are wronged by being made into members of certain social kinds under unjust conditions. Psychiatry does not merely misinterpret patients; it actively constitutes them as members of stigmatized and subordinated social categories. And often never let them out of that.

Being classified as “mentally ill” is not a neutral descriptive act. It restructures a person’s social reality: it affects credibility, autonomy, access to resources, and future opportunities. Even in the absence of overt abuse, the mere fact of being positioned within psychiatric categories can be harmful in itself. This harm is ontic rather than merely epistemic.

When such harms are structural, pervasive, and enduring, they amount to ontic oppression. Psychiatric patients are subjected to ongoing patterns of exclusion, dependency, and disempowerment that shape their social existence over time. The injustice lies not only in what is done to them, but in what they are made into within social and institutional structures.

Psychiatry and the Faces of Oppression

Iris Marion Young’s account of oppression as a structural phenomenon — rather than the result of individual bad intentions — provides a powerful framework for understanding psychiatric injustice. Several of Young’s “faces of oppression” clearly apply.

Exploitation occurs when psychiatric systems rely on underpaid or unpaid labor. Patients’ data are routinely used for research purposes; unpaid care work by women and family members stabilizes psychiatric systems; and nursing staff and care workers themselves are often exploited. These forms of labor extraction sustain institutions while obscuring their costs.

Marginalization is pervasive. Psychiatric patients are excluded from labor markets, housing, education, and social participation. Long-term institutionalization and forensic psychiatry remove individuals from public life altogether. Poverty, migration, and trauma are frequently pathologized rather than addressed as structural injustices. Psychiatry thus does not merely respond to marginalization but can actively produce it. Residential group settings that mix individuals with entirely different diagnoses are often experienced as forms of ghettoization, spatially and symbolically removed from social normality.

Powerlessness is central to psychiatric oppression. Involuntary hospitalization, forced medication, restraint, and seclusion exemplify extreme asymmetries of power. Patients are often deemed incapable of rational decision-making and have little control over diagnoses, medical records, or treatment plans—despite the fact that these records shape future life chances. Psychiatric systems routinely strip individuals of autonomy and authority over their own lives.

Cultural imperialism operates through the dominance of biomedical and biochemical models of distress. Alternative cultural, spiritual, or social understandings are delegitimized. Psychiatric categories define what counts as normal thought, emotion, and behavior, while stereotypical representations of psychiatric patients as dangerous, irrational, or unreliable circulate widely. Psychiatric knowledge becomes the normative lens through which difference is interpreted.

Finally, violence is not accidental but systemic. Physical violence includes restraint, seclusion, and forced medication. Psychological violence includes humiliation, infantilization, and loss of dignity. Structural violence manifests as chronic dependency on institutions and repeated retraumatization through treatment. Following Young, violence is oppressive when it is systematically directed at a social group—and this condition clearly applies to psychiatric patients.

The Limits of Reform Within the Existing Normative Framework

If injustice in psychiatry were merely the result of individual prejudice or professional failure, epistemic justice could be achieved through better training, awareness, or ethical guidelines. However, the preceding analysis suggests that the problem is normative and structural. The dominant psychiatric model defines what counts as rationality, credibility, insight, normality, and even reality itself. Within such a framework, patients' voices can be included only conditionally and revocably.

This raises a deeper normative question:

What should count as normal in psychiatry? Who defines normality, and on what epistemic and moral grounds?

The "New Normal" as a Normative Reorientation

The concept of a "new normal" refers to a fundamental redefinition of the normative standards that govern psychiatric knowledge and practice. Rather than treating biomedical interpretation, diagnostic authority, and professional expertise as default epistemic baselines, the new normal shifts the center of gravity toward epistemic justice, relational autonomy, and lived experience.

A new normal in psychiatry would reject the assumption that psychiatric patients are prima facie less rational or less credible. Instead, it would treat patients as epistemic agents whose knowledge is situated but not inferior, partial but not defective. This reorientation aligns with Fricker's call to correct credibility deficits, with Jenkins' insistence on transforming unjust social kinds, and with Young's demand to dismantle structural oppression rather than merely mitigate its effects.

Pathways Toward Epistemic Justice in Psychiatry

Several existing movements and frameworks point toward such a new normal. Critical and emancipatory movements—including Mad Studies, survivor research, the recovery movement, and peer support initiatives—challenge the dominance of professionalized psychiatric knowledge. They foreground first-person experience as a legitimate and indispensable source of understanding mental distress. These movements do not deny suffering or the need for support, but they resist being ontologically reduced to diagnostic categories.

The development of new linguistic forms is central to epistemic justice. Expanding the vocabulary available to describe psychological suffering, psychiatric violence, and recovery is essential for overcoming hermeneutical injustice. Without shared interpretive resources, experiences remain unintelligible or are forced into diagnostic frameworks that distort their meaning.

Culturally sensitive psychiatry further destabilizes the universality claims of biomedical models. By recognizing culturally embedded understandings of distress, healing, and personhood, it challenges cultural imperialism and opens space for pluralistic epistemologies.

At the institutional and legal level, the UN Convention on the Rights of Persons with Disabilities (CRPD) provides a normative benchmark. Its emphasis on legal capacity, non-discrimination, and freedom from coercion directly confronts entrenched psychiatric practices such as involuntary treatment and substituted decision-making. Interpreted seriously, the CRPD demands not incremental reform but a transformation of psychiatric norms and power relations.

Redefining Normativity: From Control to Epistemic Partnership

A genuinely epistemically just psychiatric model would reconceptualize clinical relationships as epistemic partnerships rather than hierarchical authority structures. This entails redistributing interpretive authority, limiting coercion, and institutionalizing mechanisms through which patients can contest diagnoses, records, and treatment decisions that shape their lives.

Such a model does not eliminate expertise but situates it within a pluralistic epistemic ecology. Professional knowledge becomes one resource among others, rather than the final arbiter of meaning. Normality is no longer defined by conformity to diagnostic norms but by the capacity of social and institutional environments to accommodate difference without domination.

Compensation for Wrongful Psychiatric Treatment: Legal Frameworks, Case Law, and Institutional Claims

Psychiatric treatment presents distinctive legal and ethical challenges due to its intersection with questions of autonomy, risk, capacity, and state authority. Unlike many other medical specialties, psychiatry permits involuntary confinement and treatment under specified legal conditions. When such interventions are carried out negligently, unlawfully, or abusively, individuals may seek compensation through civil litigation or human rights mechanisms. However, establishing legal liability in psychiatric contexts often involves heightened evidentiary and normative complexity.

Medical Malpractice and Negligence - Legal Foundations

Psychiatric malpractice claims generally follow conventional tort principles. Plaintiffs must establish:

1. A duty of care
2. A breach of the applicable professional standard;
3. Causation;
4. Legally cognizable damages (Appelbaum, 2008).

In psychiatric practice, breaches may include misdiagnosis, improper medication management, failure to obtain informed consent, inadequate suicide risk assessment, or negligent use of electroconvulsive therapy (ECT).

Challenges Specific to Psychiatry

Unlike many somatic conditions, psychiatric diagnoses are often interpretive and based on symptom clusters rather than biomarkers. Courts frequently defer to professional discretion where standards are contested (Morse, 1994). Proving causation may be particularly difficult when harm involves psychological deterioration or long-term functional impairment.

In the United States, malpractice litigation in psychiatry has addressed issues such as negligent suicide risk management and adverse effects of psychotropic medication. Although large verdicts occur, courts often require substantial expert testimony to establish deviation from professional norms.

Unlawful Involuntary Confinement and Coercive Treatment

Civil Liberties Protections

A second major category involves unlawful deprivation of liberty. In many jurisdictions, psychiatric detention must satisfy statutory and constitutional standards, typically requiring evidence of danger to self or others or severe incapacity.

In the United States, the Supreme Court in *O'Connor v. Donaldson* (1975) held that a non-dangerous individual capable of surviving safely in freedom cannot be confined solely on the basis of mental illness. This case established that civil commitment requires more than diagnostic labeling.

Within Europe, Article 5 of the European Convention on Human Rights protects against arbitrary detention. The European Court of Human Rights has clarified in *Winterwerp v. the Netherlands* (1979) that lawful psychiatric detention requires objective medical expertise and procedural safeguards.

Compensation Through Human Rights Mechanisms

When unlawful detention or coercive treatment is established, courts may award damages for non-pecuniary harm. The European Court of Human Rights frequently grants “just satisfaction” under Article 41 for violations of liberty or dignity (European Court of Human Rights, 2023).

Human rights claims often frame psychiatric mistreatment not merely as professional negligence but as violations of fundamental dignity and autonomy.

Systemic and Historical Institutional Abuse

Institutional Responsibility

Beyond individual malpractice, compensation mechanisms have addressed systemic abuse within psychiatric or custodial institutions. These include forced sterilization programs, prolonged unlawful confinement, and abusive institutional conditions.

In Germany, post-war compensation schemes addressed victims of National Socialist sterilization policies. Similarly, redress initiatives in Canada and Ireland have compensated survivors of institutional abuse in residential and psychiatric facilities (Smith, 2018).

Disability Rights Framework

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) reframes psychiatric coercion as a potential human rights violation grounded in disability discrimination (United Nations, 2006). The CRPD Committee has increasingly questioned the compatibility of involuntary treatment regimes with contemporary disability rights standards.

This shift signals a broader movement from individual fault-based models toward structural critiques of psychiatric governance.

Structural Barriers to Compensation

Despite formal avenues for redress, psychiatric claimants face distinct structural obstacles:

- Epistemic asymmetry: Courts rely heavily on psychiatric expertise, often privileging institutional testimony over patient narratives.
- Diagnostic fluidity: Evolving standards complicate retrospective judgments about negligence.
- Causation difficulties: Psychological harm may lack clear biomedical markers.
- Statutes of limitation: Survivors of institutional abuse may face procedural barriers to late claims.

These features create what might be described as a structural imbalance in access to legal remedies, particularly where coercive authority and medical epistemology intersect.

Conclusion

Compensation for wrongful psychiatric treatment operates across multiple legal domains: tort law, constitutional law, and international human rights law. While doctrinal pathways exist for redress, structural features of psychiatric knowledge and institutional authority complicate successful claims.

Emerging disability rights norms and human rights jurisprudence increasingly challenge coercive psychiatric practices and expand the conceptual space for compensation. Future legal development may depend on reconciling patient autonomy, professional discretion, and structural accountability within mental health systems.

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