Centering Social Justice in Mental Health Practice: Epistemic Justice and Social Work Practice

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Abstract
This article examines how mental health social work practice can move outside the hegemony of the medical model using approaches that honor the centering of social justice. By using the philosophical analysis of epistemic injustice and the ethics of knowing, I move out of the traditional psychiatric and psychological conceptual frameworks and discuss new guiding principles for practice. In the context of the radical tradition in social work and the impetus to blend theory with practice, I consider the use of narrative and anti-oppressive approaches to center social justice principles in individual dyadic work as well as in wider systems family and community work and policy advocacy. I evaluate these approaches through the principles of epistemic justice and discuss the importance of a relational collaborative approach where honoring the client and exploring lived experience are central to both the concepts of testimonial justice, hermeneutic justice and anti-oppressive practice.

Keywords
social justice, field of practice, mental health, epistemic justice, social work practice

Celebrating the 35th anniversary of the publication of Radical Social Work by Brake and Bailey (1980), British social work scholar Michael Lavalette edited a collection of articles on radical social work, looking at both the heritage and the future of this tradition (Lavalette, 2015). Exploring the development of radical practice in the profession, he began with the edited Brake and Bailey’s landmark publication Radical Social Work and then looked at how anti-racism, anti-oppressive practice, and advocacy approaches were developed and refined by subsequent progressive social work scholars such as Lena Dominelli (1988, 2002, 2018) and Donna Baines (2007, 2011, 2017; Baines et al., 2019). However, the implementation of these approaches has been severely dampened by the constraints of neoliberal fiscal austerity and increasing managerialism in the social services resulting in de-skilling and de-professionalizing social workers and diminishing the role of social workers to actors in a care market system (Baines, 2017; Dustin, 2007; Lavalette, 2015; Rossiter and Heron, 2011).

One of the sources of hope which Lavalette (2015) identified was theories and practices that address injustice and inequality and can be applied despite the current neoliberal climate. It is this notion that this article seeks to explore. In the introduction to The Routledge Handbook of Critical Pedagogies for Social Work, Morley et al. (2020) identify that “there is an urgent need for critical pedagogies in social work to counter global social problems” (p. 2) and furthermore they state that there is a “lack of critical theorizing around pedagogy” (p. 2) and I would add to that a lack of theorizing around praxis, and they call for social work scholars to explore and apply new critical domains to reinvigorate social work practice and social work pedagogy.

In this article, I will discuss the work of a critical philosopher, Miranda Fricker, and apply her moral practice principles to social work praxis, illustrating how these principles can provide a guide for social workers to ensure the centering of social justice in their daily work whether it be dyadic individual work, family community, or systems work or macro advocacy and policy work. Blending theories with practice beyond the traditional interdisciplinary boundaries of psychology and psychiatry enables a fresh means of rethinking our practice. In his development of narrative therapy, social work scholar Michael White ably demonstrated the value of applying the philosophical ideas of Michel Foucault on power and knowledge and the anthropological concepts of Barbara Myerhoff to broaden the scope of social work practice (White, 1995). In this article, I will demonstrate the relevance of Fricker’s epistemological and ethical social justice principles to social work by

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mobilizing examples from the field of mental health social work practice.

I choose the field of mental health as I believe it is a site of grave power inequity, marginalization, and epistemic injustice. Madness has existed for as long as we have recorded history, but it was only with the emergence of the psychiatric profession in the 18th century that madness was medicalized and at this time it was renamed mental illness (Foucault, 1988; Leblanc & Kinsella, 2016; LeFrancois, Menzies & Reaume, 2013). In the 1960s and 1970s, an anti-psychiatric social movement took shape which protested involuntary confinement and many medical psychiatric treatment interventions and this same movement also reclaimed the name of madness from psychiatric medical dominance. This resistance became known as the Mad movement, and while there are many signifiers in circulation to describe and represent the experiences of those living with distress or mental and emotional diversity, in this article, I choose to align with the values and resistance of the Mad movement and so will employ the Mad name to signify my allyship with Mad epistemological perspectives and scholarship with the intention of moving toward epistemic justice.

Theoretical Framework

Miranda Fricker is a critical philosopher who set out to consider the intersection between epistemology or knowing and ethics. She identified a particular form of social injustice which she named epistemic injustice which occurs when a person is wronged as a knower (Fricker, 2010). Fricker elaborated on the harm that this can do and identified that there is immediate harm in not being believed and thus being rebuffed or discounted but on a deeper level “to be wronged as a knower is to be wronged in a capacity essential to human value” (p. 44). The capacity to reason and to give knowledge to others is fundamental to being human and so to be insulted or ignored in this capacity is deeply wounding. “No wonder,” Fricker said, “in contexts of oppression the powerful will be sure to undermine the powerless in just that capacity, for it provides a direct route to undermining them in their very humanity” (p. 44).

Capponi (2003) who identifies as Mad has written several powerful memoirs documenting her own experiences and the experiences of others in the Canadian mental health system. She says

> every individual is different, in spite of similar backgrounds and diagnoses, in terms of potential, character, insight, interests and abilities. These differences might be obscured by labels and behaviours, by homelessness and poverty, but they are there. And they need to be expressed in order for us to find out what makes us special, what makes us unique. The failure to see us as people, not as pathologies, continues to wear us down. (p. 150, authors italics)

This description of the experience of epistemic injustice in the mental health system resonates with Fricker’s description of the deep wounding and harm done by failing to provide a respectful platform for personal testimony. This omission can undermine autonomy and an individual’s route to humanity.

Fricker identified two main interactive fields of epistemic injustice: testimonial injustice and hermeneutic injustice. Testimonial injustice occurs when a speaker is denied credibility and is degraded, ignored, or dismissed as a reliable knower. Hermeneutic injustice is an injustice of meaning-making where a particular experience is not only not part of the collective knowledge resource but has perhaps not even been named and conceptualized. This is particularly common in relation to subjugated voices as they are subject to testimonial injustice and so are denied opportunities not only to communicate and be heard but also to put a voice to their experience and enter into dialogue in ways that might increase their own understanding of their experience. Thus, their experiences do not become part of the collective knowledge resource and therefore are not easily communicated, acknowledged, or understood. Fricker (2010) gives the example of sexual harassment to illustrate this. Prior to the collective consciousness-raising of women in the 1970s, this was an unnamed phenomenon and so was not discussed or considered in the public domain even though it was a common occurrence in the workplace. Once it was named and became part of the collective knowledge resource rules were put in place and consequences enforced. Not only were women able to communicate incidents of sexual harassment, but they also increased their own self-understanding of why they experienced feelings of violation and assault when incidents of sexual harassment occurred. Fricker calls the absence of conceptualization of an experiential phenomenon a hermeneutic gap.

Epistemic Justice and Social Work Practice in Mental Health

In her exploration of the principles of epistemic injustice, Miranda Fricker explores the two main interactive fields, namely testimonial injustice and hermeneutic injustice. She then considers the role of prejudice and stereotyping and the role of silencing or marginalizing other voices in epistemic injustice. She also considers what she calls the virtues of epistemic justice by which she means practices that will promote epistemic justice. Finally, she explores hermeneutic epistemic injustice, both how it occurs, the harm that is done and how to promote hermeneutic justice. I will follow Fricker’s order of exploration to apply these concepts to social work practice focusing on dyadic individual work in the mental health field.

In a comprehensive overview of social work practice in mental health completed in 2003, social work scholar Christine Morley identified that most social work practice in mental health revolves around implementing or supporting psychiatric medical model approaches and is built on the meta-narrative or canonical narrative of the Diagnostic Statistical Manual (DSM; Morley, 2003). Dependence on a medical model understanding of mental health is widespread in Canadian mental health social work practice and is strongly reflected in numerous social work textbooks which describe mental health social work as a
partnership with mental health teams structured around the medical model and using evidence-based approaches (Bentley, 2001; Bland et al., 2014; Gibbs, 2003; Golightly, 2020; Raines, 2019; Regehr and Glancy, 2014).

However, the medical approach to mental distress has been increasingly critiqued by service users, Mad studies, and anti-psychocentrism and anti-sanism scholars (Leblanc & Kinsella, 2016; LeFrancois, Menzies, & Reaume, 2013; Perlin, 2003; Rimke & Hunt, 2002). Unlike other fields of medicine, defining the borders of illness in psychiatry is very challenging as there is no biological validity, and diagnosis is based on cataloging symptoms. Senior psychiatrists in the American Psychiatric Association (APA) meet and through discussion reach a consensus on what is to be entered into the DSM as a diagnosis and the identifying symptoms are then outlined in detail (Paris & Phillips, 2013). Thus, psychiatric diagnosis is a subjective task (there are no biopsies or laboratory tests) and so the problem of overdiagnosis and underdiagnosis is even debated among psychiatrists (Pierre, 2013). In her critique of the medical model approach to mental distress, critical scholar Bonnie Burstow (2015) calls the DSM the “boss text”:

> It is these diagnoses—and note in the precise manner in which they are articulated in this book—that are recognized by the law, that are the basis of insurance claims, that serve as entry points into the psychiatric system, that act as co-ordinators of the system. (p. 73, author’s italics)

Furthermore, the hegemony of the lucrative Mental Health-Medical-Industrial Complex which partners the pharmaceutical industry with the DSM means that expanding the available diagnoses benefits the pharma industry’s expansionist agenda. Mental health advocacy groups and mental health research are heavily funded by the pharma industry and by comparison the funding for psychosocial treatments is negligible. Psychotherapy, peer intervention, and recovery approaches have no commercial product to sell. The APA receives a vast annual income from the DSM and as pharma influence is so pervasive, it is highly likely that this percolates into epistemological decisions around diagnostic categories as well as influencing research initiatives that are funded by the pharma industry and then provide evidence-based research weight to these approaches (Burstow, 2015; Sadler, 2013).

In a recent Canadian study where mental health social workers were consulted on their views regarding service delivery, they stated that “the importance of family relationships, community supports and the influence of structural and cultural factors that can contribute to oppression is often unrecognized in a bio-medical model” (pp. 3–4). They identified that many mental health difficulties arise in the context of the social determinants of health which largely remain outside the scope of medical model responses. In addition to the dimension of responding to systemic and structural issues which trigger and contribute to mental distress, there is centering listening in therapeutic conversations. The report recommends that social work practice in mental health be repositioned so that social workers can respond with social justice-centered praxis to supplement and enrich the services offered, rather than being handmaidens to the medical model (Brown et al., 2020). To further consider the application of Fricker’s ideas, I will discuss her central principles in the context of individual dyadic clinical social work practice.

**Types of Epistemic Injustice in Therapeutic Conversations**

**Discounting, ignoring, or minimizing client experience.** Fricker (2010) identified discounting, ignoring, or minimizing a person’s account of their lived experience as the fundamental act of testimonial injustice. Operationalizing the principles of epistemic justice in dyadic conversations means centering empathic and active listening to ensure that discounting, ignoring, and minimizing do not occur. Relational thinking has been core in social work since the inception of the profession where centering “the inherent worth of the human being, the uniqueness of the individual, beginning where the client is, the centrality of the client-worker relationship in the helping process, and the importance of genuineness and mutuality” (Goldstein et al., 2009, p. xv) has been the gold standard. Psychotherapy scholars have long noted the importance of empathic listening, genuineness, and the use of self in building a collaborative and trusting relationship with clients (Berzoff et al., 2016; Herman, 2015; Norcross, 2011). Of equal importance is communicating respect and attentional listening back to the client through paraphrasing and summarizing (Johnstone, 2020).

**Labeling and stereotyping.** Fricker (2010) identified stereotypes as a basic mechanism in testimonial exchange and described how these cognitive frameworks of meaning or heuristics determine our credibility judgments. In the case of prejudicial stereotypes where there are disparaging associations between a social group and certain attributes, then this becomes systematic testimonial injustice and this form of pervasive and ongoing injustice is deeply harmful. When this identity prejudice is internalized, then a person listening to testimony will have a distorted credibility judgment and perception of the speaker. Fricker notes that a person who has persistent experiences of this kind of epistemic exclusion and testimonial injustice is harmed and that this “genuinely inhibits the development of an essential aspect of a person’s identity” (p. 54).

Then, there is a particular type of social power which Fricker calls identity power which is when stereotypic essentialized identities are ascribed to groups. Using Foucault’s idea that power is socially distributed in a net-like organization and is never held in the hands of a single person but rather fluid, changing and dispersed, she developed a model of the social power inherent in epistemic injustice where “this capacity may be exercised (passively or actively) by particular social agents, or alternatively, it may operate purely structurally” (Fricker, 2010, p. 13). In other words, these identities can be agential, that is, self-ascribed or part of the collective social imagination. In a testimonial exchange, these identities become critical factors:
if the stereotype embodies a prejudice that works against the speaker, then two things follow: there is an epistemic dysfunction in the exchange—the hearer makes an unduly deflated judgement of the speaker’s credibility, perhaps missing out on knowledge as a result: and the hearer does something ethically bad—the speaker is wrongfully undermined in her capacity as a knower. (Fricker, 2010, p. 17)

These concepts are of vital relevance to the social work profession as the identity power of many of the vulnerable populations we work with are subject to identity prejudice, and these prejudices can be outside of our awareness. For example, persons with mental illness diagnoses, persons involved in the criminal justice system, families under child protection surveillance, persons struggling with addictions, or persons living in poverty are all members of groups with diminished identity power. In contrast to this, social workers, correctional workers, police officers, psychiatrists, and psychologists have enhanced credibility and so in this credibility economy, the stage is set for epistemic injustice to occur.

Sanism is a form of social identity power that oppresses Mad people which has been strengthened by the percolating of psychiatric diagnoses and conceptualizations of mental illness into the collective knowledge resources of everyday experience. This form of oppression includes negative stereotyping, discrimination, and arguments that Mad individuals are not worthy of membership in the professions or for many parts of life (Poole & Ward, 2013). Poole illustrates the social power of sanism by discussing the common human experience of grief. She completes a comprehensive literature review of traditional psychocentric approaches to grief generated through psychological and psychiatric scholarship which are all overlaid with a Western preference for a linear progressive sequence of resolution to the experience of loss. Benchmarks have been identified as indicators of what is considered “uncomplicated” “normal” and “good” responses to grief. Thus, this psychocentric version of bereavement creates normal and abnormal grieving responses complete with a time line so those grieving outside the prescribed time limits are not eligible for bereavement leave and are referred for psychiatric interventions. Furthermore, “other” stories about grief which do not conform to the established story of normal grief are excluded from the collective knowledge resources. Communicating testimonies or Mad knowledge has become the bedrock of the Mad movement to disrupt the assumptions in the collective knowledge resource and exert epistemic resistance to psychiatric epistemic violence. For social work praxis, understanding this social phenomenon and ongoing reflexive practice is essential.

Active ignorance: Leading people to underestimate their potential. Social injustice is always accompanied and underwritten by epistemic injustice, which supports and reinforces the dominant narrative. Feminist philosopher Jose Medina (2013) notes that Racist and sexist ideologies make us all cognitively worse off: they instill distrust; they lead people to underestimate and overestimate their cognitive capacities; and they are the breeding ground for all kinds of biases and prejudices that distort perception, judgement, and reasoning. (p. 26)

Medina notes that groups who have been systematically marginalized such as women and racial minorities are usually also epistemically demeaned as intellectually inferior and lacking credibility and correspondingly the privileged groups overestimate their cognitive powers and style themselves as intellectually superior. Because of these relationships, dynamics persons belonging to marginalized groups are at risk of lacking personal and interpersonal knowledge and esteem as they are excluded from knowledge exchange, and as a result, their capacity to hear and be heard is compromised (Medina, 2013).

Sanism is the pervasive belief system or discourse that drives the oppression of Mad people. As social work scholar Jennifer Poole notes “you don’t have to have a diagnosis to experience sanism . . . you just have to look, or sound, or feel, or smell a little bit different than the everyday” (Dumbrell & Ward, 2019; Poole, 2014). Sanism was described in the 1960s and was later popularized by a disability rights lawyer called Michael Perlin who established that structural stigma, prejudice, and discrimination were used against persons who were considered disabled, and he then used this phenomenon in his legal arguments of defense (LeBlanc & Kinsella, 2016). He described sanism as “an irrational prejudice of the same quality and character of other irrational prejudices that cause prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry” (p. 536). Sanism claims that sane people are different from insane people and validates the idea that human problems or deficits are lodged in pathological individuals rather than being the result of social and structural inequities. It is the medically based psychiatric profession that has built on this idea and established the socially acceptable and “scientifically” established norms and authority to rule on who is sane and who is insane (LeBlanc & Kinsella, 2016). The ideas which embolden sanist discourses are pervasive and often reside outside of awareness.

Reid and Poole (2013) interviewed Mad identified social work students about their experience in the classroom. While this survey interviewed only eight students, the results are thought-provoking as they suggest that anti-oppressive practice is taught but not modeled in the social work university setting. Students reported that if they came out as Mad, their peers were supportive however many of the professors and the university counselors were not and interviewees reported being told that they should consider another profession and there was a reluctance to provide accommodations and to organize accessibility for them. They experienced being viewed as “needy, difficult, and unworthy of what was perceived as special treatment” (p. 217). They reported that courses in mental health social work which were offered were based on the medical model. In addition, the language used in classrooms by both student peers and professors was not respectful with indiscriminate use
of expressions such as “crazy” and “insane” and Mad people spoken of pejoratively. The author of the paper discussed her own coming out as a Mad Professor and how to her astonishment this triggered the arrival of numerous students to her office to disclose their own accounts of Madness and experiences of marginalization in the academic community. Not only must critical reflection to identify and deconstruct pervasive oppressive discourses be integral to social work education, but anti-oppressive principles need to be embedded and modeled in our pedagogy.

Silencing or narrative erasure. Exclusion from participation in a communicative exchange is another form of epistemic injustice, when the opinions from marginalized groups are not sought. An example of this is medical model psy knowledges that are held to be the official version of the truth and so alternative views are given no quarter. Social work scholar Clive Baldwin (2013) calls this narrative erasure which reflects the power that influences how stories are told and who listens to them. Psychiatric diagnosis and labeling, which represent a prescriptive medical narrative, are examples of this, as these narratives of identity override any existing narratives of identity. Baldwin observes that narrative foreclosure

means that some stories are celebrated and welcomed, while others are deliberately discouraged from being told, with negative consequences for those whose stories are shut down. On a pragmatic level the effects of this could range from larger narratives that disenfranchise considerable groups of people to smaller, individual stories that cast a person as possessing moral or personal defects. (p. 105)

An example of this is powerfully described by Capponi (1992) who is herself a psychiatric survivor and has written several memoirs describing her experiences living with other psychiatric survivors, and she tells the story of Alice who was told that she was going to be transferred to a rural psychiatric facility and in an act of resistance she ran away. Upon being returned to the facility the psychiatric nurse destroys her personal photographs and tells her that this past is now gone. Alice actually says the pictures were “all I had left of me” the only tangible remains of her identity before a prescriptive psychiatric narrative was imposed on her life, and this previous identity is destroyed by the psychiatric nurse who cuts up the pictures in her presence. Baldwin (2013) states that “narrative dispossession in the area of mental health stems from the perpetuation of medicine’s master narrative of scientific pre-eminence, professional benevolence and the maintenance of a certain notion of normality” (p. 107). The psychiatric nurse was following the medical model presumption of the expert knowledge that their regimes are in the best interests of the patients and so enforcing compliance is an act of professional benevolence. Alice is not permitted to have a voice or any participation in the decision making for her life.

Disallowing personal agency and reducing clients to cases to be managed. There is an agreement in the literature that case management services are the most effective way to deliver community mental health care (Greene et al., 2006; Ziguras & Stuart, 2000). In Canada, the federal government establishes national health standards and the individual provinces are responsible for providing the service delivery. However, critical scholars observe that the standards set by the Ministry of Health reflect the managerial approaches characteristic of a neoliberal welfare state (Goering et al., 2000; Gourlay, 1998). The focus is on housing, employment, income assistance, individual responsibility, and budgeting as well as staying out of hospital (a much more costly option than community care). Greene et al. (2006) argue that case managers are directed to assist consumers to “accept the limitations their illness created, encouraging them to manage their illness and to lower their expectations for future achievement and growth” (p. 340). Thus, case managers approach their work with a task orientation where they must “invoke authoritative voices while managing client resistance” (Lee et al., 2018, p. 11). This disallowing of personal agency is what Fricker describes as epistemic objectification which changes the participation role from one of active epistemic agent to passive object to be studied, observed, or managed.

Another example of epistemic objectification is what Baldwin (2013) describes as a form of narrative foreclosure where the stories a person tells are internalized from dominant meta-narratives. Another name for this is internalized oppression where we carry a blueprint in our individualized psyche of our culture’s oppressive patterns or narratives/discourses. This process results in experiences of helplessness, despair, and feelings of inferiority (Bishop, 2015; Mullaly, 2010). By failing to assist clients to challenge and deconstruct these internalized narratives we are contributing to a lack of personal agency.

Hermeneutical injustice: Experiencing which has yet to be conceptualized and is absent from the collective knowledge resource. Fricker (2010) describes hermeneutic injustice as developing out of social power which accumulates a collective knowledge resource of shared understandings so

the powerful tend to have appropriate understandings of their experiences ready to draw on as they make sense of their social experiences, whereas the powerless are more likely to find themselves having some social experiences through a glass darkly, with at best ill-fitting meanings to draw on in the effort to render them intelligent. (p. 148)

In the arena of mental health, the field of psychiatry draws on an ever-growing academic body of knowledge about mental illness which uses the strictures of DSM narrative formation following medical model guidelines of epidemiology. The voice of the client is excluded as they are viewed as needing help and not having any useful knowledge to contribute to finding a solution. While the hierarchy of medical psychiatric dominance in the field of mental health services remains
pervasive in Canada, the rise of mental health user narratives and the organization of psychiatric survivor movements has begun to address this significant hermeneutic gap in the field. Capponi has devoted a lifetime of research and writing to this task. In her memoir Beyond the Crazy House, she documents her personal insider experiences with several DSM categories of mental illness including her own experiences with self-harm. The DSM lists self-harm as a symptom of various personality disorders particularly borderline personality disorder and it is viewed as certain evidence of irrationality and mental illness (i.e., contrary to what is assumed as sane). Capponi (2003) says:

But there were benefits. You could see the wound or the burn. You could bind it, stitch it, watch it heal. It seemed to relieve the dreadful pressure of the moment, like an escape valve. Although professionals first thought these cuts were incompetent and laughable attempts at suicide, for many of us, they were actually an attempt to stay alive. (p. 130)

This insider account of self-harm behavior is startlingly different from the official abbreviated psychiatric description which regards the behavior as a destructive symptom serving no purpose and needing to be stopped. Capponi recounts several first voice accounts of self-harm and common themes emerge of countering the numbness from psychoactive medication, relieving emotional despair through visible physical wounding and regaining a sense of personal agency. These accounts are examples of establishing new hermeneutic knowledge and beginning to fill the hermeneutic gap. Fricker addresses the harm that hermeneutic marginalization can do as this is always a form of powerlessness:

The various ways in which loss of epistemic confidence may hinder one’s epistemic career are, to reiterate, that it can cause literal loss of knowledge, that it may prevent one from gaining new knowledge, and more generally, that it is likely to stop one gaining certain important epistemic virtues such as intellectual courage. (Fricker, 2010, p. 163)

This loss of intellectual courage or confidence in your own abilities and understanding of the world is corrosive as it can undermine personal resiliency and coping. Fricker (2010) notes that hermeneutical injustice is structural and becomes evident in the subject’s hermeneutical marginalization. There is no agent who perpetrates hermeneutical marginalization as it is a phenomenon that occurs through omission and absence.

**Implications for Social Work Practice**

Fricker describes what she calls hermeneutical virtues which are her postulations on how we can counter these forms of epistemic injustice. She suggests that reserving judgment and listening without interruption even when it does not appear to make sense are essential to forestall testimonial injustice. This correlates strongly with central social work practice which is centered on relational collaborative therapeutic conversations. Herrnemetic injustice is more complex as the territory is one of omission, absence and the unknown, and filling the hermeneutic gap means venturing into conversations where there are no tidy conceptualizations, terms, and articulations to communicate with so inevitably the communication will be exploratory and halting. Providing conversational opportunities for this is imperative as it is in the sharing and climate of epistemic testimonial justice where these new knowledges can begin to take shape.

An example of the development of an institution devoted to practicing hermeneutic epistemic justice is the development of the Hearing Voices Network in 2020. This network which began in the 1980s in the wake of the anti-psychiatry movement has now established branches in 20 countries and offers a range of resources including websites, training, conferences, hearing voices groups, and insider information on psychosis and mental illness diagnoses. The websites are well maintained and there are online support resources available to members. In the early 1990s, the Dulwich Centre in Adelaide, Australia, and the South Australian Council of Social Services collaborated to explore ways to strengthen consumer and carer participation in community mental health initiatives. A community mental health project called “Power to our Journeys” was set up which set out to “expose the tactics and effects of ‘voices and visions’ (often referred to as the auditory and visual hallucinations of schizophrenia) experienced by community members” (Dulwich Centre Newsletter, 1997, p. 3). This group met monthly, and Michael White was invited to record the conversations and create documents. In the words of one of the participants this project of epistemic justice consolidated:

our evolving knowledges and the development of our skills of living…this group has played a very significant part in rekindling our love for life, and in assisting us to achieve a quality of life we could never have predicted. It is our hope that others who are struggling with troublesome voices and visions will find hope in what we have to say here. (p. 26)

This project exemplifies the principles of epistemic justice, in that it is the organization of marginalized and excluded voices in the mental health system into a collaborative forum where the marginalized knowledges of consumers can be shared and conceptualized. It is a kind of consciousness-raising that enables the hermeneutic gap surrounding the experience of psychosis to be filled and Michael White (a social worker) becomes the agent of epistemic testimonial justice in listening and recording the findings of the group. A testimonial statement of empowerment from one of the consumer participants of this project captures the reversal from the sense of powerlessness, lack of personal agency, and loss of intellectual courage which Fricker describes as resulting from hermeneutic marginalization:

It appears that the voices have no answer to the creation of these networks (referring to the Hearing Voices Network). This means a lot. As we journey together in this work, we are becoming better
focused, more able to get our feet firmly on the ground in regaining control over our lives, and we are experiencing the personal dignity that is our entitlement. (Dulwich Centre Newsletter, 1997, p. 33)

Consumers thus spoke urgently about the need for networks such as the Hearing Voices Network as social isolation is another significant effect of hermeneutic marginalization. In the words of one of the participants:

When you are first diagnosed as having a mental illness you lose all your friends. So being treated as a friend by everyone at the gathering was very comforting. (Dulwich Centre Newsletter, 1995, p. 37)

Social work scholar Clive Baldwin (2013) views narrative ideas as ideally suited to joining theory and practice in social work as if we can learn about the stories people tell about their own lives we are better placed to intervene or not intervene in those narratives. If we apply Fricker’s ethical framework of epistemological justice to this narrative approach, then listening to stories and unpacking stories is practicing testimonial justice and in the case of new fields of knowing, then hermeneutical justice or the exploration of meaning can be practiced.

Narrative social work has been developed from linguistic and philosophical theories of narrative accounts which postulate that storytelling is fundamental to human functioning. Within this perspective, narrative accounts are understood as ubiquitous and present in all dimensions of human life. We construct personal narratives about ourselves and our lives, about our families and our friends, about our geographical locations, about our communities, and about societal pressures. Any story we tell is usually linked to other stories and meta-narratives or master narratives or dominant discourses which serve as socially shared understandings or repositories of common norms (Baldwin, 2013). For example, in his account of work with Syrian refugees, narrative social worker David Denborough (2018) describes how he was contacted by a secondary school in Adelaide to assist in working with newly arrived Syrian refugees. While interviewing school personnel to find out what the interests of these students were Denborough discovered that there were two Syrian students who had arrived 6 months earlier and since graduated from a mainstream school. He contacted these students and asked them to assist him by sharing what they had learned of adjustment in a new city. Together, they drafted a letter which included:

rich acknowledgements of the hardships faced by loved ones in Syria... profound worries about relatives still in zones of war; the experience of being in refugee camps in Jordan or Turkey; getting hopelessly lost in a new city; the struggles of fathers who are totally new to English; the profoundly disconcerting quietness of Adelaide nights. (p. 31)

Jointly Denborough and the two Syrian students described the experience of a refugee arriving and settling in Australia and how they developed skills in “learning a new language, forming new friendships and living life with a passion to help others when they first arrive” (p. 31). This letter was sent to the newly arrived Syrian students and this began an ongoing correspondence. Thus, Denborough mobilized the power of testimonial justice in listening and recording the stories and testimony of the two groups of refugees but also hermeneutic justice as the insider story of being a newcomer Syrian refugee in Australia was recorded and conceptualized through the resulting exchange of correspondence and sharing of experiences and reflections on the experiences.

If we listen to the stories that individual people tell us but also listen to the stories that their families tell, then we can position ourselves accordingly, and if we understand the political and cultural stories that surround the situations they confront, then the better equipped we are to act (Baldwin, 2013). White (1995) says that

our lives are constituted through narrative, it really is not possible to take the position that “one story is as good as another”. We should make it our business to attend to the real effects of those stories that constitute persons’ lives. (p. 14)

In other words, we must listen to each person we interact with. We cannot assume a stereotypic profile or diagnosis (Fricker calls this preemptive testimonial injustice) nor can we assume that wider discourses have had certain effects. We must practice testimonial justice by listening attentively and exploring how the stories people tell of their lives are constructed and how these stories have constituted the life of the person and their family.

External societal processes influence which stories get told, and how they can be told and this involves the frameworks of power which surround stories. Baldwin identifies canonicality as a kind of measuring stick for stories where they are judged in accordance with their conformity to the generally understood template for a canonical narrative in a particular area (Baldwin, 2013). Thus, if someone with mental health troubles does not exhibit linearity, coherence, or organization, then their narrative will be regarded as symptomatic and overruled by the medical narrative of illness requiring treatment. This act of diagnosis can precipitate ongoing testimonial injustice if we are not alert to the inherent dangers of this power imbalance.

Active listening is a central skill in ensuring testimonial justice and is taught in most introductory practice texts (Harms & Pierce, 2019; Shebib, 2019). Similarly, the importance of the therapeutic working relationship and the use of self to convey genuineness, nonjudgmental listening; to bear witness; and to communicate empathy and acceptance have long been recognized as a central facet of social work. However, with the neoliberal constraints of fiscal efficiency and accountability, the delivery of mental health services has become increasingly task-oriented and the intervention focus is on problem-solving and immediate solutions rather than on building a therapeutic
relationship and listening carefully to the client’s experience and understanding of the problem (Dominelli, 2010; Dustin, 2007; Lee et al., 2018).

In 2008, social work scholar Grant Larsen posited that anti-oppressive practice and medical model practice were incompatible. He echoed Morley’s findings that social work practice falls short in its social justice commitment when it tailors its approach to the medical model. Larsen argued that service users should be full participants in all aspects of the mental health services, that social workers should use language and discourse that is respectful, egalitarian, and empowering, and actively deconstruct the medical model with service users and their families (Larsen, 2008). These principles conform with Fricker’s concepts of testimonial epistemic justice and hermeneutic epistemic justice. Clinical social work skills such as open-ended relational approaches which model trust and mutual respect while appreciating the importance of structural and systemic oppression and marginalization for achieving social justice must be central to operationalize epistemic justice (Baines et al., 2019; Brown, 2020).

A further extension of epistemic justice would be embracing a model of service delivery which harnesses service user values and perspectives more robustly. The continued adherence to the power divisions of the medical model where the practitioner is expert and has expert knowledge moves social work in the direction of “overestimating their cognitive abilities” and thus unintentionally becoming agents of oppression. Dumbrill and Yee (2019) points out that “there is a long-held assumption that if someone needs social work, this must result from them not knowing what to do or from being unable to do it; otherwise, why would they come to a social worker for help?” (p. 256). To honor the voice of the client and practice epistemic justice, we need to effectively center service user knowledge and service user theory in our approaches.

Social work scholars Wilson and Beresford (2000) challenge the social work profession to recognize the oppressive practices of social control (and epistemic injustice) embedded in a façade of “anti-oppressive practice” which appropriates and incorporates the knowledges and experiences of service users, whilst still retaining the power to determine what it is that counts as “anti-oppressive” which is for us the most oppressive aspect of its “anti-oppressive” stance. (p. 565)

Wilson and Beresford describe the tension between the profession serving the state by implementing state mandates and policies and thus ensuring employment and state recognition and advocating for programs driven by service user theory which may risk losing state funding. They suggest that a philosophy of independent living accompanied by an emancipatory model of practice that includes service user values and ideas should be the foundation of a social work practice model (Beresford, 2015). This position is not a negation of the expertise which the social work profession can bring to the table. Social work scholar Catrina Brown (2007) suggests that in collaborative practice where there is a focus on coproduction, both the social worker and the service user can bring partial knowledge to the conversation (Brown, 2007; Haraway, 1988). This approach avoids the epistemic oppression of the “expert” and recognizes that each participant brings partial knowledge and is an active subject who contributes to the structuring and shaping of the process in accordance with their rights and needs.

The therapist is understood to have more power by way of their institutional and professional roles and because the client is the one who is vulnerable in this context. However, the emphasis and ethical stance in critical clinical practice involves increasing shared power in the therapeutic context by stressing safety, client power, and control over their own choices, and transparency throughout the work. Within this collaborative approach, clients’ stories are contextualized and their strengths and agency, alongside their vulnerability, marginalization, and pain, are emphasized. Taken together, this encourages rather than shuts down possibilities for living a preferred life and identity. (Brown, 2020, p. 58)

Conclusion

The ideas and insights offered by the philosophical examination of epistemic injustice have potent relevance to social work praxis. Lavalette (2015) describes the social work profession today as at the crossroads as we strive to uphold our commitment to centering social justice in all our work in the face of neoliberal constraints and impositions. He suggests that to move contemporary radical social work forward, we need to make the political nature of social work explicit, develop a critically reflexive approach, make alliances with service users, develop a practice based on social justice, and act collectively. While the principles of testimonial and hermeneutic epistemic justice are central to all these action areas, I explored the implications of testimonial and hermeneutic (in)justice in dyadic clinical social work. These principles concretely identify the importance of a critical clinical approach where there is an open acknowledgment of power differentials and social inequalities, and the social worker is available, accessible, and nonjudgmental. The client is respected as a good informant and the client’s knowledge and experience shape the therapeutic relationship which is grounded on epistemic justice. By mobilizing an anti-oppressive approach that is rooted in critical reflexivity and respect for the knowledge and experience of the client, we can mitigate falling into the oppressive trap of being an expert, failing to listen to our clients, and furthering epistemic injustice.

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