

Epistemic injustice in psychiatric practice: epistemic duties and the phenomenological approach

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Received 6 July 2020

Revised 11 December 2020

Accepted 13 December 2020

Published Online First

19 February 2021

ABSTRACT

Epistemic injustice is a kind of injustice that arises when one's capacity as an epistemic subject (eg, a knower, a reasoner) is wrongfully denied. In recent years it has been argued that psychiatric patients are often harmed in their capacity as knowers and suffer from various forms of epistemic injustice that they encounter in psychiatric services. Acknowledging that epistemic injustice is a multifaceted problem in psychiatry calls for an adequate response. In this paper I argue that, given that psychiatric patients deserve epistemic respect and have a certain epistemic privilege, healthcare professionals have a *pro tanto* epistemic duty to attend to and/or solicit reports of patients' first-person experiences in order to prevent epistemic losses. I discuss the nature and scope of this epistemic duty and point to one interesting consequence. In order to prevent epistemic losses, healthcare professionals may need to provide some patients with resources and tools for expressing their experiences and first-person knowledge, such as those that have been developed within the phenomenological approach. I discuss the risk of secondary testimonial and hermeneutical injustice that the practice of relying on such external tools might pose and survey some ways to mitigate it.

INTRODUCTION

Epistemic injustice in psychiatric practice is a great concern.^{1–3} It has been argued that psychiatric patients are often harmed in their capacity as knowers and suffer from testimonial, hermeneutical^{1,3} and contributory⁴ injustice because of negative prejudices and stereotypes held towards them,¹ as well as because of their status as non-expert, lay participants in healthcare systems.³

This is an unfortunate situation. Psychiatric patients, by having direct access to and knowledge of their experiences, have a certain epistemic privilege.^{2,3} The dominant approach in modern psychiatry has been to provide concise, operationalised criteria that would improve the validity of clinical diagnoses.^{5,6} Psychiatric healthcare systems are predominantly organised in accordance with this approach and often function under considerable time and resource pressure. Despite recent important attempts to prevent it,⁷ a lot of important and interesting information about patients' experiences can be inadvertently lost.^{3,4} Bueter³ argues that the inclusion of patients and their representatives may be one measure to counter some such negative effects and avoid epistemic injustice. Moreover, the phenomenological approach has been argued to provide tools for mitigating some of the negative effects of epistemic injustice in healthcare in general and in the psychiatric context in particular.^{1,8,9}

This paper takes the plea for greater inclusion of patients' perspective as a starting point. What are the specific obligations that healthcare professionals might have in order to avoid the common forms of epistemic injustice? I argue that, given that psychiatric patients deserve epistemic respect and have a certain epistemic privilege, healthcare professionals have a *pro tanto* epistemic duty to attend to and/or solicit reports of patients' first-person experiences in order to prevent epistemic losses in healthcare interactions. I discuss the nature and scope of this duty and suggest that it has to be weighed against other duties of healthcare professionals. Acknowledging such a duty has an interesting consequence: in order to solicit patients' experiences healthcare professionals may need to provide some of them with *tools* for expressing their experiences, for example, those delivered by the phenomenological approach.⁸ This latter suggestion reveals an important tension between relying on one's own resources to share experiences and on adopting seemingly external tools. A new worry arises concerning the risk of *secondary* forms of testimonial and hermeneutical injustice when relying on such external tools. I will survey some ways to mitigate this risk, which suggest that it might be useful to rely on tools that draw on a mixture of personal and professional experience and knowledge.²

The goal of the paper is to move the debate forward by first acknowledging the epistemic forms of injustice in psychiatric healthcare and then pointing out and critically discussing the epistemic duties of healthcare professionals, the realisation of which could provide a starting point for improving the situation.

EPISTEMIC INJUSTICE IN PSYCHIATRY: A COMPLEX LANDSCAPE

Epistemic injustice arises when one's capacity as an epistemic subject is wrongfully denied.¹⁰ In such cases a subject is harmed by having their capacity to engage in epistemic practices undermined. The two common forms of epistemic injustice described by Fricker¹⁰ are *testimonial*, where the subject's words and/or capacity to provide knowledge are wrongfully assigned less credibility; and *hermeneutical*, where the subject is harmed in their capacity of making sense of their own experiences.

Patient-centred approaches and therapies have been a big step in recognising patients' voice and autonomy in psychiatric services.⁷ It is nevertheless the case that psychiatric patients are often vulnerable to various forms of epistemic injustice. They report experiences of not being listened to or taken seriously by healthcare professionals, of



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To cite: Drożdżowicz A.
J Med Ethics 2021;**47**:e69.

being presumed to not fully understand their experiences and not being considered as sources of knowledge or information.¹¹ Steslow¹² provides a report from a patient who was about to be hospitalised:

Everything I said or did was taken to be a product of my illness and categorized accordingly. I had questions and worries and thoughts and had a good deal of imagination, but I was cut off from all meaningful conversation by the veil of my diagnosis, through which my speech and behaviors passed before doctors and nurses heard, saw, and interpreted them. (p30)

The example illustrates a case of testimonial injustice in the psychiatric healthcare context. Psychiatric patients can also suffer from hermeneutical injustice: when both patients and healthcare professionals lack epistemic resources to express or understand patients' experiences, a lot of valuable information about their first-person experience may be lost.¹¹ According to Crichton *et al*,¹ there are three main types of global contributory conditions for epistemic injustice in psychiatric services. First, psychiatric patients are often disadvantaged in various ways (e.g., socially, economically, cognitively). Their epistemic contributions are thus often negatively valued on the basis of their other disadvantages. In public perception, people with mental disorders are sometimes seen as responsible for these disadvantages, which reinforces marginalisation. Next, a common cause of epistemic injustice in psychiatry is that healthcare professionals often exhibit a preference for 'hard', objective evidence, while they tend to devalue 'soft', subjective evidence provided by patients. As a result, a patient, instead of being a participant in an epistemic search for diagnosis and treatment, might be seen as an object of epistemic enquiry. Finally, *negative stereotypes* of psychiatric illness that some healthcare professionals (and society more broadly) hold towards those who suffer from mental illness are another factor.¹ For example, people with mental illness are sometimes taken to be responsible for their mental illness, as in depression (see Scrutton²), while people suffering from schizophrenia are sometimes seen as unpredictable and violent. Such stereotypes contribute systematic grounds for epistemic injustice where psychiatric patients are seen as irrational, unreliable and epistemically incapable and are thus wrongfully harmed as epistemic subjects.¹

Another form of epistemic injustice that has been argued to arise in psychiatric services is *contributory injustice*.¹³ It occurs when a marginalised group cannot contribute their perspective and experience because their contribution is systematically dismissed by a privileged group, leading to epistemic loss. In contrast to cases of hermeneutical injustice, the marginalised group has epistemic resources necessary for expressing their experience. According to Miller Tate, contributory injustice affects psychiatric patients who hear voices, leading to their significant disadvantage as healthcare users.⁴ Patients' perspectives and meaningful narratives concerning hearing voices, as advocated by the Hearing Voices Network, are commonly rejected in psychiatric services, a practice that in his view leads to contributory injustice.⁴

Finally, an important concern is a structural epistemic injustice that impacts on diagnostic criteria and classifications in psychiatry.^{3, 14} Bueter argues that the exclusion of patients and their perspectives in taxonomic decision making in psychiatry constitutes a special kind of epistemic injustice, a *pre-emptive testimonial injustice*.³ In such cases testimonies coming from psychiatric patients regarding their experience and treatment are wrongly presumed to be irrelevant and often not even solicited.

According to Bueter, patients are excluded from taxonomic decision making in virtue of *not being experts*: the lay status of their testimonies leads to pre-emptive injustice.³ This is problematic, since patients' perspective and experience can provide invaluable information for diagnostic process and treatment.^{1, 2} Such information is important for value-laden judgements in classifications and can provide means for revising already existing criteria. Thus we should actively seek to integrate patients and their representatives in taxonomic decision making.^{3, 14}

Epistemic injustice can take various forms in psychiatry, has multiple sources and affects psychiatric patients in various, plausibly intersecting ways. The accurate charting of this complex landscape is an important task that can further our understanding of the epistemic difficulties that psychiatric patients may face in healthcare contexts (see also Kurs and Grinshpoon¹¹). However, it is far from being the end-goal in this debate. Acknowledging that epistemic injustice is a multifaceted problem in psychiatric services calls for an adequate response. In the remainder of this paper I move this discussion one step further by pointing out and critically discussing specific epistemic duties of healthcare professionals, the realisation of which could provide a starting point for mitigating some effects of epistemic injustice in psychiatric practice.

PATIENTS' EPISTEMIC PRIVILEGE AND EPISTEMIC DUTIES OF HEALTHCARE PROFESSIONALS

Epistemic injustice in psychiatric services is a well-documented and by now also well-studied problem. But how are we to address it in an informed and systematic manner? I believe that a starting point for at least some systematic interventions to counter epistemic injustice in psychiatric services is by acknowledging relevant epistemic duties. I argue that healthcare professionals have a *pro tanto epistemic duty* to attend to and/or solicit patients' reports of their first-person experiences in order to prevent epistemic losses in their interactions with patients. I critically discuss the nature and scope of this duty and show that it needs to be weighed against other duties of healthcare professionals and may be over-ridden.

It is an open question whether healthcare professionals are morally responsible for various forms of epistemic injustice in psychiatric services. According to Fricker,¹⁰ agents who lack concepts or reasons necessary for them to correct for epistemic injustice are excused. If healthcare professionals lack resources to correct for epistemic injustice, then perhaps they could be excused. Moreover, most healthcare professionals would probably not consciously subscribe to negative stereotypes towards psychiatric patients that underlie these forms of epistemic injustice.^{1, 2} Such negative attitudes, as many implicit beliefs, might fall outside their conscious control.^{15, 16} However, given that negative stereotypes and attitudes towards psychiatric patients can lead to the above-described harm and injustice and that we all seem to have general duties to avoid injustice in general, it is nevertheless plausible that healthcare professionals have specific *duties* to avoid and respond to such forms of epistemic injustice.

It is often observed that when we provide others with information, that is, testify, we are bound by some normative principles. Those are typically spelled out as various norms of assertion that impose on testifiers a duty to assert something (say something) only if they can do so truthfully, if they have reliable information or if they know about it.^{17–19} Typical patient–healthcare professionals interactions in psychiatric services are normally cooperative and patients who report their experiences do so in order to provide relevant information that

will, in their opinion, benefit the epistemic task at hand, for example, arriving at a diagnosis, deciding on the treatment, or following up on their condition. Therefore, there are no principled reasons to suppose that patients who volunteer reports of their experiences to healthcare professionals do not speak truthfully and to the best of their knowledge. In recent debates on epistemic injustice, some have argued that those who receive testimony owe speakers some kind of *epistemic respect*: an acknowledgement of the claimed authority that comes with providing information and a recognition of the obligation to treat this authority in an epistemically appropriate manner²⁰ (see also Anderson, Dotson and Goldberg^{21–23}). We can thus argue that healthcare professionals owe psychiatric patients who volunteer information about their experiences respect as epistemic subjects. Epistemic respect is one reason that can justify duties for healthcare professionals to attend to patients' reports of their first-person experiences. Taking one step further, one could argue that psychiatric patients who meet the above-described testimonial standards (of speaking truthfully and to the best of their knowledge) may have a default expectation that they will be trusted (for general discussion see Fricker and Simpson^{10 24}; for criticism see Goldberg²⁵).

There is *another* fundamental reason that can justify *specific epistemic* duties of healthcare professionals in this context. Experiences and subjective perspectives of psychiatric patients are a rich reservoir of information.^{3 6 26 27} Patients' reports of their experiences can provide invaluable information for diagnostic process, treatment, as well as for taxonomic decisions, and as such should not be ignored.^{1–3} Scrutton² argues that the epistemic injustice that arises from the dominant third-person, medical perspective in psychiatric services can be countered by acknowledging that psychiatric patients are in fact *epistemically privileged*. They often have epistemically privileged access to knowledge of what the experience is like and, in some cases, knowledge of what is good for them in terms of treatment. I argue that acknowledging patients' epistemic privilege is another reason that allows us to derive specific obligations in the context of a typical, cooperative interaction between psychiatric patients and healthcare professionals. Healthcare professionals have *pro tanto epistemic duties* to attend to or/and actively try to solicit such reports in order to prevent substantial epistemic losses in their interaction with patients. This is because such losses may and often do significantly affect understanding of the patient's condition, as well as their treatment. Patients' epistemic privilege regarding their experiences leads to such epistemic duties on the part of healthcare professionals. But it is important to note that healthcare professionals have another kind of epistemic privilege.¹ In virtue of their professional knowledge they can provide clinical interpretations of patients' experiences and understand their implications for diagnosis and therapy. The two epistemic perspectives may be occasionally in tension, for example when altered perception and delusion are part of the investigated condition.

Moreover, epistemic duties of healthcare professionals to attend to/solicit patients' experiences may occasionally be in tension with the time and resource constraints on healthcare systems and fulfilling them might not be always feasible.

If information volunteered by a patient cannot be easily used in diagnostic and treatment decisions, then why should healthcare professionals attend to and/or solicit such reports? One initially plausible reply is that such epistemic duties are arguably more basic than practical considerations of whether and how the volunteered information can be further used. Our modes of attending and drawing on information in specific contexts, including healthcare systems, may result from historical and conventional constraints and be problematic. An interesting, although complex, example to consider in this context concerns the early discovery and use of anaesthetics, an example first discussed as an instance of testimonial injustice by Carel and Kidd.⁹ Although nitrous oxide and its analgesic properties were discovered in 1795, it was used only from 1846. For almost 50 years testimonies that nitrous oxide provides pain relief for patients undergoing surgeries were ignored.^{9 28} There are many reasons behind this initial resistance to anaesthesia, for example biblical passages stating that women would bear children in pain or modesty preventing female patients from being unconscious in the presence of men.²⁹ Despite such historical constraints, testimonies about pain relief should have been given attention. On the other hand, doctors' epistemic duty to attend to such testimonies might have clashed with duties to respect patients' autonomy and to secure their consent and participation in the decision making during the surgical process. In psychiatry, however, the proposed epistemic duty is intended precisely to strengthen patients' autonomy. Whether such a *pro tanto* duty can be actually fulfilled will often be partly dependent on resource and context constraints.

This leads to another important issue: the *pro tanto epistemic duty* to solicit reports of patients' experiences may in some cases compete with other duties of psychiatric healthcare professionals. Healthcare professionals are typically bound by duties to protect the safety and life of the patient and others, to effectively use finite resources or to provide quick access to appropriate therapy. The epistemic duty to solicit reports of patients' experiences may occasionally be in tension with such duties. A vivid example is when the epistemic duty clashes with the duty to protect the patient: soliciting reports of some experiences may cause anxiety or be particularly painful, and could thus be detrimental to the patient. Such negative consequences have to be weighed against possible benefits that following epistemic duties might bring.¹¹ Epistemic duties to prevent epistemic losses and solicit information from patients are grounded in expectations about such epistemic interactions.¹⁰ Soliciting and attending to patients' reports of their experiences can have important mutual epistemic benefits for participants in epistemic interactions that underlie many psychiatric services. But a critical discussion reveals that the epistemic duty to attend to/solicit patients' experiences in psychiatric services has to be weighed against resource constraints and competing duties of healthcare professionals and may sometimes be over-ridden. The implementation of epistemic duties requires that they are explicitly communicated and discussed with healthcare professionals as part of their training, where cases of competing duties are analysed and some strategies for addressing them are provided beforehand.

¹I thank an anonymous reviewer for several very helpful suggestions for developing discussion presented in the remainder of the paper.

¹¹I thank an anonymous reviewer for helpful suggestions concerning this problem.

While many psychiatric patients are capable of and do volunteer information about their first-person experiences, not all of them might be able to do so. Some patients, although willing to share their experiences, may not have the conceptual nor linguistic resources required for the task. In some such cases, and given the above epistemic duty, healthcare professionals might need to actively try to foster patients' expressive abilities. Not equipping patients with such resources and not soliciting their experiences might lead to important epistemic losses. This last observation requires detailed attention, as it raises interesting ethical questions that will be now discussed.

THE PHENOMENOLOGICAL TOOLKIT AND THE RISK OF SECONDARY INJUSTICE(S)

Can epistemic losses be prevented by healthcare professionals in cases where psychiatric patients lack resources to express their experiences? And if so, how? The gap between the medical and existential understanding of illness is a common complaint about healthcare services. To bridge this gap and solicit patients' experiences, healthcare professionals can rely on various diagnostic and therapeutic models, such as patient-centred approaches, psychotherapy and creative therapies including art, drama and music therapies.^{7 30 31} One important advantage is that these approaches can be tailored to patients' needs to effectively enable the expression of experiences. One limitation is that many of them require additional resources outside the basic care in psychiatry. I will now focus on one particular approach based on the phenomenological tradition that has recently been argued to provide resources to help psychiatric patients conceptualise their experiences^{8 9} as well as resources for healthcare professionals to engage with and understand patients' reports of experiences, and could be applicable as part of the basic care in psychiatry. Carel and Kidd⁹ argue that the phenomenological approach can provide means to ameliorate epistemic injustice in healthcare services, including psychiatric services. We need to enable healthcare workers to *regularly* engage with patients' subjective point of view, where perspective taking exercises are an important part of the training and practice. The phenomenological toolkit proposed by Carel⁸ is a resource for both patients and healthcare professionals. It provides philosophical concepts from the phenomenological tradition through which the impact of their illness, and of caring for the ill, can be conceptualised and understood. By giving the patients and healthcare professionals the ability to interpret the experiences of the former, the toolkit may help ameliorate epistemic injustice. It consists in three steps^{8 9}: bracketing the natural attitude towards illness; thematising illness by attending to its various aspects and making them explicit; and reviewing the ill person's being in the world, for example, by capturing the pervasive effects of illness.

Although the results of this particular method require empirical investigation, the phenomenological approach seems to be among the currently promising approaches that could aid fulfilling duties to counter epistemic injustice in psychiatric services and avoiding epistemic loss. However, as any tool, it can be implemented in various ways. The need to occasionally equip patients with phenomenological tools reveals an important tension between relying on one's own conceptual resources to share experiences and adopting external tools such as those provided by the phenomenological approach. Scrutton discusses some important epistemic problems that might arise when relying on the phenomenological approach in psychiatric services.² First, the tools may be developed on the basis of phenomenological research that focuses on experiences of

highly educated patients, thereby opening for a risk of further marginalisation of less-educated patients. Second, phenomenological tools may sometimes rest on perceived expectations about experiences and applying them might result in a skewed description of one's experiences.² In such cases, applying the phenomenological approach to help patients express their experiences might pose a risk of secondary forms of testimonial and hermeneutical injustice. This is because the original form of patients' reports of their first-person experiences may be either dismissed or not solicited, if those are misdescribed or forced into imposed categories.

One way to address these problems could be to encourage plurality and facilitate both linguistic and non-linguistic forms of expressing experiences, as suggested by Carel.⁸ The phenomenological toolkit would thus not presuppose particular ways of interpreting and understanding experiences, but rather provide means of attending to them and communicating them to others. The approach could thus be fruitfully combined with the above-mentioned models of soliciting patients' experiences, such as patient-centred care and creative therapies. Another way could be to develop phenomenological tools that rely on a mixture of first-person experience and professional knowledge of mental illness.² In this spirit, some phenomenological tools might need to be tailored to specific mental illnesses and developed together by professionals and patients. Recent philosophical work on the temporal dimension of experiences in depression³² could be useful for thematising mood disorders, by inviting patients to reflect on changes in their subjective perception of time. Phenomenological work on disembodiment in schizophrenia³³ could aid developing tools for identifying experiences that may indicate relapse. It is important not only to recognise the above epistemic duties of healthcare professionals, but also to be aware of the above secondary epistemic problems. This issue requires further investigation also given that, as noted above, the relationship between healthcare experts and patients raises concerns about epistemic privileges of both sides when understanding experiences. Mitigating epistemic injustice might also require adopting explicit professional guidelines for patient–doctor interactions in psychiatric services (for general guidelines see Dugdale *et al*³⁴).

Healthcare professionals have a *pro tanto* epistemic duty to solicit reports of psychiatric patients' experiences and enable such reports with the best means possible. The phenomenological approach is among the tools for implementing this duty. But the implementation of such tools is a delicate matter: we should be wary of secondary epistemic injustices and be open to other approaches.

CONCLUSION

I have argued that healthcare professionals working in psychiatric services owe their patients epistemic respect and have a *pro tanto* epistemic duty to attend to and/or solicit patients' reports of their first-person experiences in order to prevent epistemic losses. This duty has to be weighed against other duties of healthcare professionals and its implementation requires a careful choice of tools. When adopting tools provided by the phenomenological approach, healthcare professionals might need to consider secondary epistemic injustices.

Acknowledgements I would like to thank Andreas Brekke Carlsson and two anonymous reviewers for detailed comments and very helpful suggestions for this paper.

Contributors AD is the sole contributor to this paper.

Funding This work was supported by the Mobility Grant Fellowship Programme (FRICON) funded by The Research Council of Norway and the Marie Skłodowska-Curie Programme (project number: 275251).

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

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