EVALUATING ALTERNATIVE PERSPECTIVES ON PSYCHIATRIC DIAGNOSIS

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ABSTRACT
This paper highlights the need for improved practices in the process of psychiatric diagnosis and criteria revision that are more inclusive of the lived experiences of patients. I argue that there are harms inherent in the process of receiving a psychiatric diagnosis and that these harms can lead to a loss of epistemic self-trust in patients. I evaluate two perspectives that emphasize the importance of collaborative approaches and identify the need for lived experiences to be considered at the institutional level, where they are most obviously absent, for meaningful change to occur.

KEY WORDS
Psychiatry, diagnosis, epistemic justice, self-trust, lived experience.

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Psychiatric diagnosis and its effects on patients have been widely discussed in the philosophical literature. While many who receive a diagnosis find it helpful and explanatory, others have reported feelings of stigma, shame, and hopelessness (Johnstone, 2014). It has been argued that traditional, symptom-based models of diagnosis can be problematic and face many challenges including false positives, misclassification, and inaccuracy when addressing comorbid conditions. In response, several alternative perspectives have been explored. Advocating for the inclusion of patient perspectives in the development and revision of diagnostic criteria is one of several 'calls for change' that aim to address the historically exclusionary practices within clinical psychiatry that can leave patients vulnerable to harm. These harms, which occur when patients experience epistemic injustice,[1] include a loss of self-trust and self-esteem, decreased likelihood of seeking treatment, and worse overall health outcomes.

With an aim to assess proposals that have been put forward to expand the role of the patient/service user[2] in scientific research and criteria revision, my paper explores two questions: can we conceptualize psychiatric diagnosis in a way that adequately considers patient experiences whilst maintaining clinical utility? Can this goal be aided by either of the perspectives discussed in the following analysis, while simultaneously avoiding epistemic harms to patients? Answers to these questions can help determine whether new approaches will improve patient experiences within psychiatry and reduce the harms inherent in the process of receiving a psychiatric diagnosis. I believe we need an approach that better integrates patient knowledge and expertise at the institutional level[3] — where it is most obviously absent — and that these alternatives should be considered in light of changing perspectives and attitudes within and outside of psychiatry. In this paper, I argue that traditional approaches to diagnosis undermine epistemic self-trust in patients, and that alternative perspectives may serve as a guiding light for psychiatry to help protect and promote trust in the diagnostic process whilst preventing harm. If patients do not feel that their voices are being heard and taken seriously at every level, it is difficult to promote trustworthiness in the diagnostic process. This paper emphasizes this trust deficit and its implications at the institutional level.

The challenges described herein emphasize the need for improved diagnostic practices. I present two perspectives to support my argument: Lucy Johnstone's explanation of the 'psychological formulation' model and Serife

Tekin's 'experience-based expertise' method. I begin by illustrating the need for these approaches and for greater patient integration by providing several arguments highlighting systemic issues in the process of psychiatric diagnosis. I then state and explain the alternative diagnostic perspectives discussed by Johnstone and Tekin before advancing to a critical discussion of these methods and their applications, especially as they pertain to expanding patient involvement in the revision of diagnostic criteria. I conclude by mentioning a few potential challenges these perspectives may face.

THE NEED FOR ALTERNATIVES

In this section, I provide examples to justify the need for new approaches to psychiatric diagnosis and criteria revision processes. First, the process of receiving a psychiatric diagnosis is often fraught with obstacles for patients. Barriers to adequate health care access include communicative difficulties, economic disenfranchisement, cultural stigma, and a lack of cooperation between different medical specialities. Issues like these can lead to negative encounters with practitioners and the broader healthcare system, where patients may have their experiences questioned or disbelieved. Crichton et al. (2017) claim that despite the best of intentions, physicians often do not believe what psychiatric patients tell them (p. 65). In many cases, patient testimonies and interpretations are not considered credible, and they may be even more vulnerable to epistemic injustice than those experiencing physical illness. There are many reasons for this, including the view that ill persons are cognitively impaired or emotionally compromised due to their illness and/or their emotional reaction to it. It is understandable that illness invokes strong emotional responses in those who experience it, but Crichton et al. believe these strong feelings may at times be misinterpreted by practitioners as the patient being overdramatic, exaggerating, or that the patient's condition has detrimentally affected their thinking and reasoning processes (p. 66). As a result, patients often report feelings of hopelessness and desperation when seeking and receiving mental health care.

Second, there is an underlying lack of trustworthiness in the diagnostic process. This has been described as a "credibility crisis" for decades, owing in part to its value-laden nature and a complicated history of public distrust and misrepresentation (Bueter, 2018, p. 4711). Many factors have contributed to this lack of patient trustworthiness in psychiatry and in the diagnostic process, including the difficulty of establishing a reliable taxonomy to classify mental disorders and a lack of representation of patient perspectives at the institutional level. Classifying mental disorders necessitates a high degree of complexity, as they involve a range of interacting factors including biological, social, environmental, and psychological considerations (p. 4719). One proposed solution to this credibility crisis is a greater integration of patient perspectives into the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) revision process. This would mean involving patients as actual decision-makers, rather than having them merely represented by scientific experts (p. 4711). Bueter (2018) argues that trustworthiness "requires that value-laden decisions are made in a manner that takes patients' values and expectations into account" and that *public* epistemic trustworthiness requires a reason for the public to believe that patients' values are represented in the decision-making process — something that has not been achieved with confidence thus far (p. 4712).

In DSM revisions, patients have historically been represented by a single individual on a Task Force which supervised and coordinated efforts to revise diagnostic criteria within the DSM-5. This Task Force consisted of 28 members, only one of which was a civilian representative of a mental health group; the actual revision of diagnostic criteria was done by 13 work groups primarily composed of psychiatrists, social workers, and psychiatric nurses (p. 4724). This kind of representation does not seem to go far enough in helping patients feel that their voices are being heard. The problem is further complicated by the issue of competing values amongst stakeholders. It is well understood that making a psychiatric diagnosis also necessitates the involvement of values, since the criteria put forth by the DSM is meant only to serve as a

guide (Sadler, 2002, p. 108). There is much debate within the literature about how to determine which values are legitimate and illegitimate, and what roles they should play. That debate is tangential to this paper, as it requires a more in-depth analysis than I can provide here.

Within psychiatry, it is up to the clinician to apply their own experience and knowledge to the defined criteria, in combination with the patient's history and symptoms, to determine a suitable diagnosis. Considering the DSM's role as a guidebook, it is expected that concerns about accuracy and reliability will arise, as the criteria it puts forth can influence public policy, insurance eligibility, access to social services, court cases and more (Wakefield 2010, p. 9). If patients do not feel fairly represented or served by the mental health system, it is difficult to establish a foundation of trust. It is partly this subjectivity, alongside a lack of transparency and other factors, that has contributed to psychiatry's credibility crisis and prompted calls for improvement.

Other reasons for setting aside traditional approaches to diagnosis include arguments that regard it as a form of colonialism (Timimi, 2014). Westernized ideals of mental health literacy being applied in non-industrialized nations can be problematic, damaging traditional cultural notions of health and disease and inadvertently setting standards for normality "by categorizing what emotional and behavioural traits and experiences should be considered 'disordered'" (Timimi, 2014, p. 212). Existing approaches to diagnosis may also increase stigma, worsen long-term prognoses for mental health problems, and fail to aid treatment decisions in many cases (p. 208). A lack of consensus on these matters suggests that current approaches may not be as widely applicable — or reliable — as previously thought.

Lastly, a lack of biological certainty around the aetiology of mental disorders further underscores the need for different approaches. Thus far, most research efforts have "fail[ed] to reveal any specific biological or psychological marker[s]" that are clearly indicative of psychiatric conditions, and the validity of a diagnostic construct "depends on the extent to which it represents a naturally occurring category" (Timimi, 2014, p. 209). Owing to an overall lack of identifiable properties beyond symptoms and behaviours, diagnostic categories are unlike other models in medicine, as there can be more empirical variability within the formulations used to construct them. According to David Kupfer, chair of the DSM-5 Task Force, we are still awaiting the establishment of biomarkers for mental disorders. In the absence of such discoveries, he claims, "it is clinical experience and evidence, as well as growing empirical research, that have advanced our understanding of disorders…" (Kupfer, 2013, p. 1). Thus, in the absence of a widely applicable scientific framework upon which to base diagnostic categories, the importance of the patient/service user perspective is further emphasized, as these perspectives can help to close the existing gaps in understanding how mental disorders should be categorized. The issues mentioned in this section are not an inclusive list but provide insight into why alternative approaches should be explored and their potential in illustrating where patient integration could be improved.

PSYCHOLOGICAL FORMULATIONS

Having provided examples illustrating the lack of credibility and trustworthiness facing the diagnostic process, I will now discuss approaches that aim to reduce the epistemic harms described. As stated, one possible solution to this crisis of trust is the use of alternative diagnostic approaches, such as those proposed by Lucy Johnstone (2018). She describes the function of diagnosis as one that "promotes the idea [that] psychiatry is a branch of medicine — just like neurology, oncology, pediatrics, and so on — in which the main cause of a person's difficulties is thought to be [something wrong] with the functioning of the body or brain" (Johnstone, 2018, p. 31). Unlike medicine, however, Johnstone believes psychiatry does not have a reliable way of describing and grouping basic elements to shape and develop theories. Therefore, challenges with validity and classification prompt us to question whether certain forms of suffering or distress are best understood as disease processes (p. 31). Jerome Wakefield (2007) shares this conclusion, stating that there is no consensus on the meaning

of 'mental disorder' and a major difficulty for psychiatry lies in trying to define a mental condition as a medical disorder rather than "a normal form of human suffering or a problem in living." (p. 149).

In her paper, Johnstone argues that the single most damaging effect of psychiatric diagnosis is a loss of meaning. By divesting people's experiences of their personal, social, and cultural significance, diagnosis "turns 'people with problems' into 'patients with illnesses'." (Johnstone, 2018, p. 31) As a result, experiences of trauma, abuse, and discrimination "are sealed off behind a label as the individual is launched into what is often a lifelong journey with disability [and] exclusion." (Johnstone, 2018, p. 31) This is of particular concern at the institutional level, where patient experiences are often distilled down and divested of this crucial individual element, if they are included at all.

In response to these harms, Johnstone analyzes *psychological formulation*, defined as the process of co-constructing a hypothesis of 'best guess' about the origins of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense they've made of them (p. 32). This practice draws equally on two sources of expertise: the knowledge of clinicians, whose expertise is derived from theory, research, and experience; and insights from patients, whose expertise arises from their lived experience in the context of their relationships and circumstances. Unlike conventional approaches to diagnosis, Johnstone claims, psychological formulation is not about making expert judgements, nor about emphasizing perceived deficits. Instead, it draws attention to a patient's resources and strengths in adapting and surviving challenging life situations (p. 32).

In this framework, all diagnoses should proceed from the assumption that 'at some level it all makes sense' — no matter how unusual, confusing, or overwhelming someone's thoughts, feelings, and behaviours might appear. The central task of mental health professionals, therefore, is to work alongside patients to create meaning out of chaos and despair, and Johnstone believes psychological formulation is a powerful and effective way to do this (p. 33). Her work describes what is essentially a mainstream practice conducted within the fields of psychology and psychiatry — a type of biopsychosocial assessment — that many clinicians spend years practicing.[4] She believes that the most important function of any alternative approach to psychiatric diagnosis is to restore the meaning in madness. Johnstone claims that genuine alternatives, because they can threaten the 'status quo', will often face increased scrutiny, opposition, and discreditation. They can also be "stripped of their most challenging aspects and be absorbed into the existing system," something that has mostly occurred with formulation (Johnstone, 2018, p. 31). However, at its core, formulation "is the tool used by clinicians to relate theory to practice." (Butler, 1998, p. 2 as cited in Johnstone 2018, p. 32) Described as a core skill of the profession of clinical psychology, it also appears in regulatory requirements for counselling, health, and forensic psychologists in addition to being a key competence in U.K. psychiatrists' training curriculum (pp. 31-32).

Despite its appeal, Johnstone acknowledges that psychological formulation may not always avoid the same pitfalls of DSM-based diagnosis, such as pathologizing experiences or imposing views that a patient disagrees with (p. 34). She claims that much depends on how the process is conducted; when successful, formulation has been described by patients as increasing their trust and understanding, as being empowering, 'a relief', and giving them the ability to move forward. Johnstone (2018) states that in practice, psychological formulation should consider three things: (1) any trauma and abuse experienced by the patient; (2) the role of services in compounding the difficulties [being experienced] (i.e., if repeated painful recollections cause a patient to be retraumatized); and (3) "a critical awareness of the wider societal context within which formulation takes place." (p. 34).

The intention of the above is to minimize the individuating tendency of both medical and (some) psychotherapeutic models which, by locating the difficulties within the person, convey a message of blame and deficit. Psychological

formulation is best thought of as an accompaniment to psychiatric diagnosis, as "best practice formulations ... are not premised on psychiatric diagnosis. Rather, the experiences that may have led to a psychiatric diagnosis (low mood, unusual beliefs, etc.) are themselves formulated." (Johnstone, 2018, p. 39) Essentially, Johnstone's (2018) argument is that if formulation can provide a reasonably complete explanation for the experiences that led up to receiving a psychiatric diagnosis, then there is no place or need for a competing hypothesis that says, "by the way, it is also because she has schizophrenia [that the patient experiences certain phenomena]" as it becomes redundant (p. 39). Overall, psychological formulation places less emphasis on labels and more on the lived experience of mental illness through the eyes of the patient, an approach embraced by Serife Tekin. Her 'expertise-by-experience' model will be discussed next.

PATIENT EXPERTISE-BY-EXPERIENCE

When listening to the experiences of patients in psychiatric practice, we are aiming to uncover the unique insight that can only be accessed through their lived experience. Doing so requires a rebalancing of epistemic authority,[5] which is granted to the agent whose judgement replaces or supersedes that of another in a particular context (e.g., in a physician's relationship with a patient). Typically, this epistemic privilege is granted to the practitioner, as they are presumed to have a certain kind of expertise (and by extension, epistemic authority) by virtue of their position, education, and clinical experience. Consequently, clinical encounters can result in what Miranda Fricker (2007) calls 'testimonial injustice', which occurs when an existing prejudice held by a hearer lessens the credibility granted to a speaker's word.

Jasna Russo (2023) describes how, in the psychiatric context, this form of injustice usually captures the expectation that 'stigmas' around mental illness can (or ought) to be resolved within individual encounters and by increasing practitioner awareness (p. 2). Typically, supporters of this approach conclude that listening to patients instead of asserting that experts know best would help counter stigma and experiences of diminished agency. While acknowledging the good intentions behind such a perspective, Russo feels that it does not go far enough and asks whether, in the long term, it can meaningfully counteract the testimonial injustice faced by persons with psychiatric diagnoses. She therefore asserts that framing mental illness through this approach "reduces testimonial injustice to (poor) clinical practice, to be remedied by improving relationships with patients" (Russo, 2023, p. 2). Russo (2023) further believes that such presumptions "detach clinical encounters from [their] broader structural context and obviate the potential of the concept of epistemic injustice to bring about social change for psychiatrically diagnosed persons." (p. 2) She is concerned that framing testimonial injustice as primarily occurring within individual clinical encounters risks abstracting away from the broader, systemic factors that contribute to the issue. Instead, we might look towards redefining how 'authority' and expertise is understood — which is the sort of approach imagined by Serife Tekin in her expertise-by-experience method.

Tekin (2020) discusses the role of experience-based expertise in psychiatry, arguing that individuals diagnosed with mental disorders are 'experience-based' experts on their conditions and should therefore be included in scientific research aiming to expand knowledge in psychiatry. Her view seeks to challenge the notion that patients lack the needed expertise to meaningfully contribute to psychiatric research (p. 79). She claims that historically, individuals diagnosed with mental disorders have not systematically been included in scientific inquiries into mental disorders. Their legitimacy as stakeholders has been repeatedly undermined and their perspectives discredited. She describes the subjectivity of their experiences with mental disorder and perspectives on diagnostic criteria as being assets, not impediments, in the scientific process (p. 86). Tekin believes this is due to the patients' direct encounter with the phenomena of mental disorder being an experience largely unknown to (or unable to be experienced by) clinical or scientific experts. Therefore, including patients in the knowledge production process

allows transformative criticism by ensuring that different points of view are part of the scientific decision-making process (p. 87). It is my view that Tekin's perspective helps support the need for integrating of patient perspectives at the research and institutional levels. Thus far, this has not been done in a meaningful way and more work remains to accomplish this goal. It is not the aim of this paper to solve this multifactorial and deeply complex issue, but to shine a light on some of the systematic issues at play in this process.

Tekin (2020) also describes how dominant diagnostic frameworks recognize and rely on scientific and clinical data to advance the science of mental disorders but are not equally committed to directly using the first-person perspectives of patients (p. 80). Within psychiatry, the presupposition is that patients are not experts. Instead, they are considered "objects of study rather than knowledge-producing subjects." (Tekin, 2020, p. 80) Tekin formulates criteria which recognizes the unique expertise patients have in virtue of their experience with mental disorders. This includes the idea that patients thoroughly understand the challenges that come with their illness(es) and can see how the illness affects different parts of their lives, such as social relationships and employment. Patients are also able to reflect on how the scientific framing of their condition (i.e. their DSM diagnosis) might impact what accommodations they receive and services they are entitled to. Tekin believes that patients who are able to sustain a 'good quality of life' despite these challenges already have strategies to cope with disruptions caused by their illness (p. 88).

According to this view, patients possess a unique 'first-person' subjective knowledge about their illness that is not readily accessible to clinicians. In essence, every person's experience of mental disorder is unique, and that person is in the best position to convey epistemic authority on their experience. This is not to suggest that traditional diagnostic approaches need to be cast aside. Rather, Tekin advocates for 'pockets of expertise' to exist alongside expert views, not to replace them (p. 88). Through this approach, Tekin aims to reimagine the role of expertise in psychiatric diagnosis as one of mutual respect, cooperation, and shared epistemic authority.

CRITICAL DISCUSSION

Reframing the discussion to become more user-focused and emphasizing the unique expertise patients can provide will help create a more inclusive approach that has the potential to increase trustworthiness in the diagnostic process. Reimagining epistemic authority in the diagnostic process also allows for reflection on the implications of diagnosis and how they affect concepts of self-understanding and self-trust in patients (Noorani, 2013). Tekin (2011) explores these themes, arguing that the DSM itself acts as a source of narrative,[6] affecting the diagnosed subjects' self-conceptions and possibilities for self-development (p. 358). On one hand, the implications of diagnosis may have positive effects by facilitating patient self-understanding through consideration of a person's experience with their disorder. When patients have insight into the broader context of their symptoms and how they fit into their experience, they are less likely to feel 'out of control' and have greater trust in the ability of practitioners to accurately diagnose and treat them. On the other hand, a model driven by a DSM diagnosis may lead the individual to treat their disorderly psychological states or behaviours as "the prototype of an illness beyond [their] control." (Tekin, 2011, p. 358) Tekin explains that the symptom-based approach of the DSM and its classifications that list symptoms corresponding to idealized versions of mental disorder,[7] along with other factors, may prevent a diagnosed person from assessing mental distress as an outcome of multiple factors, This, in turn, prevents them from developing appropriate responses to their condition. This kind of approach can create feelings of helplessness and lead patients to assume a 'sick role' (Wakefield, 2010, p. 12), which is counterproductive in establishing self-trust and trust in others to provide care and explanation.

As stated, repeated experiences of having their testimony discredited are epistemically harmful to the trust (of self and others) and self-understanding of patients. According to Heidi Grasswick (2018), epistemic trust concerns one's

willingness to take the word of another — to trust their. testimony and form beliefs based upon it (p. 75). Conditions of such trust involve judgements that the testifier is competent and sincere (pp. 75-76). Hence, epistemic self-trust is the ability to trust the integrity and acuity of one's own testimony. In the illness context, this refers to a patient's belief that they understand their own condition(s) and can convey their testimony in a way that is faithful to their experience. A loss of epistemic self-trust is a consequence of persistent and systemic epistemic injustice (Fricker, 2007). Patients who repeatedly have their testimonies questioned, doubted, or undermined are more likely to experience a loss of self-trust. This is especially problematic, Bueter (2023) claims, when it comes to interpreting one's bodily experience, as this is typically something we acknowledge a diagnosed person to have a privileged access to and that is grounded in their first-person perspective. After all, she continues, "patients are the ones who know best about what symptoms they experience." (Bueter, 2023, p. 1153) Patients must trust that practitioners will in turn trust *them* and their experiences when they undertake the process of receiving a psychiatric diagnosis, something that may be more difficult to achieve without adequate representation at the institutional level.

When assessing an individual for a mental disorder, practitioners take into consideration that distress may arise and be influenced by multiple sources including socio-economic status, traumatic events, and relationships, as well as the subject's personal assessment of their feelings, desires, beliefs, values, behaviours, and goals. However, it is important to acknowledge what distress means to an individual (i.e., its place in their narrative). It is necessary, Tekin (2011) claims, "to acknowledge the complexity of a phenomenon involving not only biological parameters but also cultural, social, and environmental factors that may escape a purely neurobiological analysis." (p. 359) In sum, both the underlying neurobiological structure of mental disorders and the external influencing factors should be considered together to achieve a more accurate understanding (e.g., the 'big picture') when making a diagnosis. The approaches described by Johnstone and Tekin could aid in promoting trustworthiness in the diagnostic process by emphasizing the relevance and importance of patient perspectives in building a comprehensive picture of mental disorder and positively influencing future changes in diagnostic frameworks. At present, evidence of such complexities and their impact on diagnostic criteria are not obvious. To my knowledge, if such considerations have been made, they are less obviously identified or discussed within the revision process.

CHALLENGES

It is largely uncontroversial to advocate for the inclusion of those with lived experience into discussions about diagnosis, but there are some challenges worth mentioning. When looking to include patient perspectives in DSM revision and scientific research, one problem with the use of patient narrative (i.e., personal experience) is that experiences of illness are not typically neat and organized. Navigating through the psychiatric system is often a nightmare scenario for many patients, particularly if they are placed into care or subjected to treatment without informed consent. Such individuals may also hear the opinions of multiple different providers, not all of whom may share the same conclusions. The lack of a clearly defined 'storyline' or 'timeline' of illness symptoms may also detract from a patient's credibility as an expert in the eyes of professionals. Non-linear narratives without a defined 'start' and 'end' point can present a unique set of challenges and are not always avoidable in practice. Cheryl Misak (2010) claims that narratives are not simply chronological accounts of events; rather, "they are accounts that give coherence or shape to events and are thus burdened with interpretation, motivation, and other [impressions]." (p. 394) Thus, aiming for any kind of objectivity is difficult due to narrator fallibility, and narratives are subject to critical scrutiny just like other forms of evidence and testimony.

A second challenge arises from the way experiences of illness are gathered and how symptoms are documented. As previously stated, a comprehensive understanding of a patient's

history and symptoms is required to make an informed diagnosis. Flanagan et al. (2010) acknowledge that current clinical interview structures typically include these biopsychosocial assessments, but they claim that it is not whether these factors are assessed that matters, but rather how they are assessed. Understanding the illness experience requires (and normally consists of) a thorough interview, and any contributing factors should be examined and understood either as tangential or as major developmental tasks and challenges comprising the person's life, therefore providing the context within which illness is experienced (p. 303). Clarifications that extend beyond clinical interpretation (i.e., what is outlined in the DSM) are essential if we are to take seriously, and meaningfully incorporate, the perspectives of those with lived experience of illness at the institutional level. Persons living with mental disorder have repeatedly been shown as "more than capable" of describing their own experiences, even those living with severe illness (Flanagan et al., 2010, p. 304). Given this understanding, it should be a natural outcome for professionals to extend the ability to describe subjective experiences to their patients and employ these descriptions to improve diagnostic criteria. Without these kinds of interviews being conducted, it is challenging to accurately portray and incorporate patient experiences.

There may also be some reluctance on the part of experts to extend the kind of trust needed to make meaningful changes to diagnostic criteria. Historically, there has been some controversy over the inclusion of patient experiences in revision processes, as they have been said to undermine the authority of experts. However, I believe that the inclusion of patient perspectives need not be taken as a threat to trained experts. In fact, such perspectives ought to be welcomed as they can help fill in the gaps, providing insight into knowledge attainable only through the unique epistemic privilege of first-hand accounts of illness. Collaborative approaches enable the patient, practitioner, and other professionals (including researchers) to work together to form a comprehensive account of illness that can be used to inform and influence future diagnostic practices and improve outcomes.

The problems discussed in this section are not inclusive of the many challenges facing the process of diagnosis and diagnostic criteria revision at present, but they provide useful insight into what changes are needed moving forward to increase patient involvement, reduce epistemic harm, and promote trust. More work remains to be done, and the perspectives mentioned herein represent a few potential ways for psychiatry to begin mending its reputation and promoting patient trustworthiness in the process of psychiatric diagnosis and the revision of diagnostic criteria.

CONCLUSION

In this paper, I have argued that alternative approaches to psychiatric diagnosis and diagnostic revision processes that better incorporate patient perspectives are needed to help protect and promote epistemic trust whilst avoiding harm. I have also addressed how traditional approaches to diagnosis and revision risk undermining epistemic self-trust in patients, and how the perspectives discussed here could aid in the revaluation and improvement of existing models. The challenges described herein emphasize the need for improved practices. The two approaches presented — Johnstone's 'psychological formulation' model and Tekin's 'experience-based expertise' method — suggest how we might reform diagnostic practices, revise criteria, and reimagine epistemic authority at the institutional level. It is my view that we can conceptualize psychiatric diagnosis in a way that adequately considers patient experiences while still being clinically useful, and that this goal could be achieved with these alternative perspectives in mind to promote trust and reduce the harms inherent in the process of receiving a psychiatric diagnosis.

ENDNOTES

1. Epistemic injustice is broadly defined as a type of injustice related to knowledge where persons experience unfair treatment. It includes exclusion and silencing; systematic distortion or misrepresentation of one's meanings or contributions; an undervaluing of one's status or standing as a 'knower' in communicative practices; unfair distinctions in authority; and unwarranted distrust (Kidd et al., 2017, p. 1).
2. I use 'patient' in much of this paper— it is not intended to express a preference for one term over the other.
3. I employ the biomedical understanding of institutional analysis in this paper; namely, that which refers to data coming from established institutions such as health authorities, hospitals, research laboratories, etc.
4. Many thanks to Dr. Suze Berkhout for increasing my understanding of this process in her valuable commentary on an earlier version of this paper.
5. Epistemic authority is the authority ascribed to certain agents in virtue of their relation to particular 'epistemic goods' (in this case, medical or psychiatric knowledge). See Zagzebski, L. T. (2012).
6. Narrative refers to an account of illness and its effects on a patient's life, told in an autobiographical fashion as a means of sense-making and expression.
7. I have interpreted an "ideal" representation of a mental disorder to be one that would meet diagnostic thresholds and display all or many of the relevant symptoms, making diagnosis clear-cut and obvious — something that rarely happens in practice.

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