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Title: **Beyond epistemic injustice: When perceived realities conflict**

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Miranda Fricker has conceptually outlined epistemic injustice to describe how knowledge from people in socially disadvantaged groups (such as women and ethnic minorities) comes to be ignored or devalued[1]. In medicine more broadly, and in psychiatry, epistemic injustice is increasingly being considered to reduce discrimination against different types of knowledge[2,3,4]. Importantly, Fricker did not extend her discussion[1] to people deemed to have mental illness or disorder (henceforth, referred to as 'lived experience'[5]). A key practical and philosophical problem regarding social inclusion in psychiatry involves the contradictory challenge of amplifying the voices of those with lived experience whilst simultaneously attempting to change their situation or their perceived reality through psychiatric intervention[2]. In this article, I argue that the unique way by which people with lived experience are categorised based on their perceptions and experiences of reality extends beyond the epistemic, or knowledge-based domain. More specifically, having one's sense of reality examined or questioned by a clinician concerns the ontological domain because it relates to the nature of reality (that which is real and not real). The consequences of this and the potential for ontological harm have not been adequately considered to date and are the focus of this article.

The processes of ignoring, devaluing or discrediting a person's experience are foundational in Fricker's description of epistemic injustice[1], which she illustrates through the example of a woman who reports sexual harassment and is not believed. This individual's knowledge of her experience is ignored or discredited based on her social location as a woman rather than factors related to the knowledge itself. In contrast, those with lived experience specifically come to belong to this group after their experiences have been examined. Typically, an expert arbitrator of accepted notions of appropriate reality experiences (such as a psychiatrist) has in fact listened to or observed them to make a psychiatric assessment. Unlike the example of the woman experiencing sexual harassment,

the testimony of people with lived experience is often central to their categorisation. For example, a person might experience unusual reality experiences such as noticing internal or external auditory or visual stimuli that a clinician considers representing 'psychosis'[5]. In such cases, the person's epistemic knowledge is used to conclude that they have a distorted perception of reality (ontology). This can then expose them to injustices relating to their ontological status if they are considered to 'lack contact' with reality.

Receiving a psychiatric diagnosis can formalise membership to a social group that is subjected to traditional epistemic injustice. For example, people can experience shame, silencing and exclusion after receiving a particularly stigmatizing diagnosis such as borderline personality disorder[6] or schizophrenia[5]. In a detailed analysis of epistemic injustice in mental illness, the philosopher Anastasia Scrutton provided the caveat that the ontological status of those with lived experience was beyond the scope of the work[2]. Elsewhere, a recent discussion of epistemic injustice in psychiatric research and practice identified a range of epistemological harms but did not consider the ontological significance of having your perceptions of reality questioned[4].

It should be noted that confusion between the epistemic and ontological domains is such a common mistake that it has a name[7]. The philosopher Roy Bhaskar called the reduction of ontology to the epistemological, "the epistemic fallacy"[7]. To delineate the nature of reality from our knowledge of it, we can take the example of a person experiencing psychosis during a psychiatric assessment. If the individual claims to hear someone in the room that the psychiatrist does not, their account may well be believed. It is the individual's senses and perceptions about the nature of reality that is called into question and tested. Their sensory and perceptual inner and outer experiences are contested in some way by a professional. The psychiatrist and the person experiencing psychosis differ on ontological terms regarding what is real and not real. Such experiences are destabilising and

distressing as they can create a loss of safety and trust in one's own body and mind[5]. This goes beyond the epistemic because any subsequent knowledge emanating from one's perceptual and sensory signals can be deemed to be tainted at source.

When there are perceived conflicts about what constitutes reality, the professional's view takes precedent which represents a type of 'ontological disparity' rather than simply an epistemic injustice. This judgement of another's sense of reality can contribute to self-alienation and a reduced sense of coherence[5]. For example, there might be a rational logic to experiencing and describing paranoia for a person with lived experience who has also been racialised throughout their life. As such, the consideration of paranoid beliefs as irrational or distorted from reality can trivialize lived experiences which might carry significant meaning[5].

The experience of being subjected to consistent doubt from an external source about the credibility or trustworthiness of your reality experiences is a distressing phenomenon, named 'gaslighting', and it can destabilise an individual's sense of self and worsen their mental health[8]. For people with lived experience, the rebuilding of their ability to trust and interpret their sensory and perceptual inner and outer experiences is made more difficult if they have been labelled with particular conditions, such as schizophrenia[5]. Being categorised in such a group can therefore result in an individual's knowledge being devalued across society (the epistemic domain), in addition to their devalued representations of reality[5] (the ontological domain).

There has been long-standing historical inertia about developing empirical accounts of unusual reality perceptions in conjunction with people with lived experience. For example, in Fusar-Poli et al.'s[5] bottom-up exploration of psychosis co-written by people with lived experience, the authors

claim it was the first of its kind in the 200-year history of psychosis research studies. We have allowed ourselves to develop collective gaps in our epistemic knowledge about unusual experiences, possibly in part because we see them as less real. Ironically, lived experience research designed to address epistemic injustice is dominated by narratives of illness from White individuals. Seminal work in the field such as 'This is survivor research'[9] contains limited insights into experiences of people from Black backgrounds despite the long-acknowledged disproportionate representation and inequitable treatment within mental health settings for Black individuals in countries such as the US and UK. This marginalisation and exclusion of people from Black backgrounds is likely an example of epistemic injustice still operating in lived experience research. However, injustices in psychiatry can also be upstream towards 'ontological disparity'. Injustices in the ontological domain are pertinent to psychiatry because these settings involve judgements about reality, such as notions of reality testing or reality distortions. This allows us to create hierarchies of power about who can and cannot judge what is real and the possibility of harm from learning one's own experiences are less real than other peoples.

Our failure to develop a cross-collaborative phenomenological empirical evidence base of unusual experiences has resulted in underdeveloped descriptive and interpretative resources for clinicians and people with lived experience to draw on. There is room for greater diversity in our language and concepts representing the variety of complicated experiences currently occupied by the arguably clumsy term 'psychosis'. Particular unusual reality experiences might also have social and cultural facets that have not been fully explored or named. Developing more representational language can help bridge the gulf in experienced realities between people with lived experience and others.

Addressing ontological disparity does not mean that professionals and researchers must abandon their own assumptions about reality, which may be informed by notions of logic and objectivity

popular in Anglo-American countries[10]. There are pragmatic opportunities to develop creative methodologies inclusive of different reality assumptions. We might be empirically curious about the concepts described, such as their potential linguistic and discursive qualities, but simultaneously interested in their corresponding quantitative features. Observational measurement and the quantification of some aspects of lived experience can still help us go a step beyond traditional notions of symptom measurement. As an example, a network analysis of the language and concepts used to describe unusual experiences could demonstrate links between linguistic features of speech or expressive writing using reproducible statistical techniques to map patterns quantitatively. In conjunction, a phenomenological analysis of the speech or expressive writing could reveal how individuals' meaning making might relate to their social locations (e.g. race, class, gender). This offers the opportunity to generate theory about the meaning of these experiences for people from particular communities. Exploring the concepts and expressions that individuals use to describe their unusual perceptual and sensory experiences also positions us to sensitively expand our vocabulary of lived experience. Furthermore, the resulting extended lexicon should allow more appropriate and nuanced support and communication from professionals when any person is experiencing crisis.

The solution to ontological disparity is not selecting one reality over the other but developing ways of co-existing where different realities are respectfully acknowledged and combining ontological stances in a joint production of knowledge. The goal is to bridge the ontological divide rather than attempt to inhabit someone else's space or displace oneself. We should also acknowledge that individuals can face ontological harm in the processes of psychiatric care which are distinct from epistemic injustice and need to be managed sensitively to help individuals maintain or restore their sense of personhood. It is within the scope of psychiatric research and practice to recognise that people with lived experience can experience ontological ruptures from experiencing a different sense of reality to others. We should look to supporting people with lived experience in transforming

their sense of self and self-coherence with respect to their unusual reality experiences not in spite of them.

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