Invisible Barriers & Invisible Disorders:

Refugees with Mental Disorders and Epistemic Injustice in the Canadian Immigration System

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June 2021

A thesis submitted to McGill University in partial fulfillment of the requirements of the degree of a Master of Science in Experimental Medicine, Specialization in Bioethics

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Abstract

The world is currently experiencing unprecedented levels of displacement. While most who are displaced become internally displaced people, there was a record number of 26 million refugees and 4.2 million asylum seekers recorded in 2019 alone. Although the response of the Canadian government has been admirable, there is also the possibility that the immigration system itself exposes refugees to harm. A person is said to experience an epistemic injustice when they are wronged in their capacity as a knower. These injustices may arise from prejudices that a listener holds, or from a lack of collective interpretive resources. Though there are many ways that a refugee may be exposed to epistemic injustice, refugees with mental disorder in particular may be more vulnerable to this form of injustice because of stereotypes and stigmas surrounding mental disorders. In analyzing the immigration system from the perspective of epistemic injustice, I identify areas where epistemic injustice might occur. Specific policies related to detention and the use of designated representatives are also identified as potentially contributing to epistemic injustice. I also identify where epistemic justice can be seen in the process and suggest strategies for further promoting epistemic justice. Based on these findings I suggest changes that could be made to prevent epistemic injustices from occurring, and the next steps that this research could take.

Résumé

Le monde connaît actuellement des niveaux de déplacement sans précédent. Alors que la plupart de ceux qui sont déplacés le deviennent à l'intérieur de leur propre pays, nous avons enregistré un nombre record de 26 millions réfugiés et 4,2 millions demandeurs d'asile rien qu'en 2019. Bien que la réponse du gouvernement canadien ait été admirable, il est également possible que le système d'immigration même expose les réfugiés à des préjudices additionnels. On dit d'une personne qu'elle subit une injustice épistémique lorsqu'elle est lésée dans sa capacité de connaisseur. Ces injustices peuvent découler des préjugés d'un auditeur ou d'un manque de ressources interprétatives collectives. Bien qu'un réfugié puisse être exposé à l'injustice épistémique de nombreuses façons, les réfugiés souffrant de troubles mentaux en particulier peuvent être plus vulnérables à cette forme d'injustice en raison des stéréotypes et de la stigmatisation qui entourent les troubles mentaux. En analysant le système d'immigration du point de vue de l'injustice épistémique, j'identifie les domaines où de telles injustices peuvent se produire. Des politiques spécifiques liées à la détention et au recours à des représentants désignés sont également identifiées comme pouvant contribuer à l'injustice épistémique. J'identifie également où la justice épistémique peut être vue dans le processus et je suggère des stratégies pour la promouvoir. Sur la base de ces résultats, je suggère des changements qui pourraient être apportés pour empêcher les injustices épistémiques de se produire et les prochaines étapes que cette recherche pourrait prendre.

Commonly Used Acronyms

- IRB – Immigration and Refugee Board of Canada
- IME – Immigration Medical Exam
- UNHCR – United Nations High Commissioner for Refugees
- CBSA – Canadian Border Services Agency
- IRCC – Immigration, Refugees and Citizenship Canada
- PTSD – Post-Traumatic Stress Disorder
- RPD – Refugee Protection Division
- RAD – Refugee Appeal Division
- IOM – International Organization for Migration
- IDP – Internally Displaced Persons
- BoC – Basis of Claim Form
- APA – American Psychiatric Association
- DSM-V – Diagnostic and Statistics Manual, 5th edition
- IRPA – Immigration and Refugee Protection Act

Acknowledgements

This thesis would not have been possible without the endless support of my supervisor, Dr. Matthew Hunt. Your constant guidance and feedback has helped me to grow as a researcher and I am so lucky to been able to learn from you. I'm not sure I would have made it through this year with a thesis if I had a different supervisor, and I cannot express how grateful I am to have had you as a mentor. Thank you so much.

Thank you to the members of my committee, Dr. Nicholas King, Dr. Phoebe Friesen, and Dr. Megan Bradley. Your feedback on this project helped me to bring it to new levels. Nick, Phoebe, I am so grateful to have been your student and to have learned about bioethics from the best. Your classes were some of the highlights of my degree.

Thank you to Dr. Lisa Eckenwiler, Dr. Ryoa Chung, and Mr. Mathieu Simard. You have been incredible supports throughout my degree, and I am so grateful for your trust in me as a research assistant and for the financial support of the SSHRC grant. I have also been incredibly lucky to be a part of the GHER lab group. Our Zoom meetings have been a bright spot over this past year.

Despite not being in the same province (or country) for most of this year, I am so grateful for my friends. Megan, Josh, thank you for being highlights of my bioethics degree. Laura, thank you for being a constant support despite the time difference. Cassa, Sarah, thank you for all the laughs, and for bringing me so much joy every time we talk. Orla, for being my second set of (French & English) eyes.

Mom, thank you for listening to me rant at the end of a long day and for constantly reminding me I could do this. Tim, thank you for all the hot chocolates and the treats and the hugs. You both mean the world to me.

Jenna, Rivka. I love you both so much. Thank you for making this last year possible, I would not have been able to do this without you. I couldn't ask for better roommates and friends.

And to me. I did it :)

Dr. Hunt helped me throughout the development of this thesis and editing it. Dr. Friesen helped me to start my research in the field of epistemic injustice. The GHER Lab group provided invaluable feedback on my literature review chapter. I, Monika Noble, wrote each chapter in this thesis, edited them, and created all tables and figures.

Chapter 1: Introduction

1.1: What is Epistemic Injustice if not Apollo's Curse Enduring

If someone is called a Kassandra it means that they have spoken truthfully but are not believed. In ancient Greek mythology, Kassandra was the daughter of King Priam and Queen Hecuba of Troy. The myth begins with Kassandra as a priestess of the god Apollo. Apollo admired her beauty and wished to win her favour. One version states that Apollo offered her the gift of prophecy in exchange for her compliance with his desires. Kassandra agreed to the deal but went back on her word after she received the gift. Another version states that Apollo gave her this gift as an enticement, with no promise on Kassandra's side. Either way, a furious Apollo curses her, such that all of her prophecies are true, but no one will ever believe her. The curse has devastating effects, the most notable being Kassandra's prediction of the fall of Troy at the hands of the Greeks, which no one believes.

As a result of Apollo's curse, everyone around Kassandra is biased against her. They interpret what she says as a sign of mental instability. Her prophecies and testimony are viewed as the ravings of a madwoman:

> Hecuba:
> Ah, not Kassandra! Wake not her
> Whom God hath maddened, lest the foe
> Mock at her dreaming. Leave me clear
> From that one edge of woe.
>
> (Euripides, 1915)

Kassandra, who is believed to have what we would call a mental disorder, is viewed as untrustworthy. She is shunned by her family and city, and harm befalls her and those around her.

The story of Kassandra, where truthful statements are systematically dismissed as non-credible, is a common one. When someone is treated in this way and wronged in their capacity as a knower, they experience an epistemic injustice. Miranda Fricker has written extensively on this topic and focuses on two forms of epistemic injustice: testimonial and hermeneutical injustice. A testimonial injustice is committed against someone when "prejudice causes a hearer to give a deflated level of credibility to a speaker's words" (Fricker, 2007, p. 1). In mythology, because Apollo's curse causes everyone to inherently disregard her prophecies as they believe she is mad, Kassandra experiences a testimonial injustice. Hermeneutical injustice arises when "a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker, 2007, p. 1). Although not explicitly stated, the citizens of Troy also experience a hermeneutical injustice due to Apollo's curse. Kassandra repeatedly prophesizes the fall of Troy to the Greek army, but because of the curse, no one believes her. Because Apollo creates this gap in resources (cursing Kassandra and rendering her knowledge useless) the Trojans meet their untimely end at the hands of the Greek soldiers.

Since Fricker's foundational work on epistemic injustice, the theoretical terrain has been further developed by scholars to include other concepts such as epistemic exclusion, epistemic privilege, epistemic oppression, and epistemic violence (Dotson, 2011, 2014; Kurs & Grinshpoon, 2018b). Fricker and other scholars have also provided positive accounts of practices that support epistemic justice through the practice of epistemic virtues. Epistemic justice is described by Fricker to be present when a listener exhibits both testimonial and hermeneutical justice (Fricker, 2007). This involves both reflexivity and awareness of one's own prejudices, as well as an openness to changing negative patterns that contribute to hermeneutical injustice (LeBlanc-

Omstead & Kinsella, 2016). Another form of epistemic justice is epistemic humility. Wardrope defines epistemic humility as "an attitude of awareness of the limitations of one's own epistemic capacities, and an active disposition to seek sources outside one's self to help overcome these shortcomings" (Wardrope, 2015, p. 350). Peled further develops this concept when talking about how language barriers can lead to experiences of epistemic injustice. The cultivation of linguistic epistemic humility (what Peled calls metalinguistic awareness) involves "the capacity for higher-order reflection over language and linguistic agency, as opposed to simply using a particular linguistic system (i.e. a particular language) to communicate and interact with others" (Y. Peled, 2018, p. 365). As positive as experiences of epistemic justice are, experience of epistemic injustice are just as negative. Epistemic injustice is particularly damaging when your safety and wellbeing relies on the person you are speaking with believing your story. This is the case for refugees with mental disorders.

The previous decade has seen a steady increase in international migration each year, with many people deciding to move because of family, study, or work (International Organization for Migration [IOM], 2019). For those who are displaced due to violence, unsafe living conditions, or climate change, the majority do not leave their home country, becoming internally displaced persons (IDPs). Those who travel beyond their home country's borders become refugees or asylum seekers[1]. By the end of 2019, the United Nations High Commissioner for Refugees (UNHCR) reported that there were 26 million refugees worldwide, and 4.2 million asylum seekers

[1] A quick note on terminology. Sometimes I specifically mention both refugees and asylum seekers, and others I use the term refugee to refer to both of these populations. Refugee is a broad category that includes asylum seekers & both groups go through a very similar immigration processes. Therefore, I sometimes use the term refugee to refer to both groups. If I wish to specifically refer to people whose refugee claim started after entering Canada, I will use asylum seeker. If I use refugee and mean to exclude asylum seekers, I will state that in the text.

(United Nations High Commissioner for Refugees [UNHCR], 2020). These numbers are expected to increase in the future.

Canada's response to what has been deemed a 'refugee crisis' has, in some ways, been admirable. In 2018 and 2019 Canada was the leading country in the world for refugee resettlement (UNHCR, 2020). However, the process of immigrating to Canada as a refugee is daunting. A refugee's journey may take years, travelling through multiple countries and staying in refugee camps. There are also strict requirements that a refugee must meet to be accepted by Canada. One key step is the Immigration Medical Exam (IME), which is a comprehensive medical assessment. Another is that they must go through an interview process. For convention refugees, the immigration interview occurs with a migration officer, and asylum seekers interview with the Immigration and Refugee Board of Canada (IRB) (Government of Canada [Canada], 2018a). Under certain circumstances, refugees or asylum seekers may also be detained upon entering Canada.

This process, which will be discussed in more depth in the coming chapters, can cause people enormous stress. Asylum seekers have described how their entire lives were centered around the immigration process, to the point where once the IRB interview was over they did not know what to do with themselves (Jacob, 2020). In addition to being incredibly time consuming, the process can also be overwhelming emotionally. One asylum seeker described how when they were writing their Basis of Claim (BoC) form they "couldn't even write a single [word], it was so depressing" (Jacob, 2020, p. 53).

While epistemic injustice can of course affect all refugees while they are immigrating, it is likely that refugees and asylum seekers with mental disorders face unique experiences of epistemic injustice due to potentially interlocking forms of inequity that the intersectionality of their identity exposes them to. However, the available literature regarding refugees with mental disorders and their experiences of epistemic injustice in Canada is sparse; few testimonials from refugees with mental disorders who have gone through this process are available in published research or reports. Because of the lack of information on this topic, we do not know where these injustices occur. There is also a lack of discussion that centers this group of people regarding their experiences with the intersections of power and knowledge, further contributing to this gap in the literature. Therefore, my thesis will attempt to address the following questions:

1) How can concepts of epistemic injustice help reveal the relationship between knowledge and power for refugees with disabilities in Canada?

2) Where and how might refugees and asylum seekers with mental disorders experience epistemic injustice in the Canadian immigration system?

In carrying out this analysis, I also consider a secondary question:

3) How can epistemic justice be promoted for refugees and asylum seekers in the Canadian immigration system?

In the following chapter I begin by discussing migration as a public health ethics issue and situating my thesis project within my field of study in bioethics. Issues surrounding migration present ethical challenges that are relevant at both the structural and interpersonal level. I then proceed to take a closer look at the current migration situation globally and the procedure for how refugees can apply to Canada for refuge. I then discuss how traumatic events during their

immigration can lead to refugees developing mental disorders or worsening pre-existing conditions.

In chapter 3 I present the theory of epistemic injustice in greater detail. I begin by discussing Miranda Fricker's seminal work on the theory, her definitions of testimonial and hermeneutical injustice, and epistemic justice. I then discuss developments of the theory, including epistemic exclusion, epistemic privilege, epistemic oppression, epistemic violence, and epistemic humility. I also consider some critiques of the theory. Finally, I discuss epistemic injustice and how it fits in this project.

The fourth and fifth chapters feature my analysis of the Immigration system, and how different aspects of a refugee's identity may affect their immigration and the potential for them to experience epistemic injustice. I discuss in depth how testimonial injustice, hermeneutical injustice, and epistemic exclusion might arise in regard to the Canadian immigration system. I also suggest changes that could be made to avoid these injustices and how epistemic justice could be promoted instead. I then expand my analysis to include gender, age, the type of mental disorder, and various other policies pertaining to immigration. I then introduce the concept of epistemic disenfranchisement, which I developed through my work on this project. Finally, I further discuss where epistemic justice could be promoted in the system in relation to these additional features. To conclude the thesis, chapter six briefly summaries the work and presents the suggestions that have arisen from this project.

1.2: Definitions, Terminology and Content Warnings

As someone who has a mental disorder, this topic and advocacy surrounding it is an area which I am very passionate about. I understand the difficulties that can arise from having a

mental disorder, and I felt that this project was a way to bring attention to how these difficulties can impact the immigration process of refugees. According to the Diagnostic and Statistics Manual, 5th edition (DSM-V), a mental disorder is "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities" (American Psychiatric Association [APA], 2013, pp. 4-5). These disorders can have a wide range of impact on people's day-to-day lives. The term 'mental disorder' is one that I use throughout this thesis to refer to conditions such as anxiety, depression, post-traumatic stress disorder (PTSD), etc. The selection of this term was one that I struggled with, as I wanted to find a term that recognized the impact that these conditions can have on the people who live with them and on that covered a wide range of conditions. I considered several alternatives, and decided that, on balance, mental disorder was best suited for my project. While the term mental disorder is more medical, I elected not to use mental health as I felt that this term does not adequately convey the seriousness of these conditions. Similarly, I chose not to use mental illness as I felt that it would exclude certain conditions that I wished to include within the sphere of my analysis. Mental disorder also refrains from labelling people as having a disability. As someone with a mental disorder I am comfortable using this phrasing, but I want to acknowledge that this may not be a label that other people with mental disorders use to identify themselves. Mental disorder also seems to be widely used in the available literature regarding refugees with these conditions, so using this term made sense for continuity's sake.

This is not to say that the term mental disorder or the above definition is without its flaws. The term 'mental disorder' is inherently medicalized. The DSM has been criticized for failing to clearly delineate between mental disorder and a normal response to distress (Pierre, 2010). The persistent question of what should count as a mental disorder is one that continues to be asked in medicine and healthcare and has yet to be answered (Pierre, 2010). In response to these concerns, some psychologists and psychiatrists have moved away from the DSM, such as Szasz and Rogers, who rejected the use of the DSM as a diagnostic system, as "diagnosis, accurate or not, need not be a prerequisite for properly caring for persons with a supposed mental disorder" (Thyer, 2015, p. 54).

In addition to critiques of the DSM and the term mental disorder itself, there have also been concerns of over-pathologizing normal responses to distress. While some refugees may have pre-established diagnoses (i.e. are going through the immigration process with an already diagnosed condition), others may be diagnosed during their immigration process. Diagnosing mental disorders in Canada and other 'destination countries' is often done through a Western biomedical lens which ignores how different cultural backgrounds can affect presentation of symptoms. Watters' writes about a struggle that can be faced by people who work with refugees and are critical of approaches that over-medicalizes distress. These individuals may have to choose whether to:

> Present the refugee's problems in terms that highlight the range of social, political and economic concerns of the refugee but that may not mobilise any resources to support the refugee and place [them] in legal jeopardy, or, alternatively, in full knowledge of the broader complexities, nevertheless present the refugee as a traumatized victim and enhance [their] claim for asylum and mobilise support. (Watters, 2001, p. 1710)

This system of diagnosing refugees also runs the risk of condensing all refugees' traumatic experiences into what is considered 'clinically significant' and not what refugees would like to share or gain from the exploration of their trauma. This can lead to refugees being the subject of "institutional responses that are influenced by stereotypes and the homogenising of refugees into a single pathologized identity" (Watters, 2001, p. 1710).

One diagnosis in particular, PTSD, has drawn specific criticism. Summerfield's 1999 critique of the assumptions behind this diagnosis highlights some of the pitfalls of diagnosing refugees with PTSD. For example, in Rwanda after the Rwandan genocide, translational issues arose as there is no word for 'stress' in Kinyarwanda, and different words are used when discussing trauma and mental health in different contexts (Summerfield, 1999). Additionally, Summerfield writes that "much of the distress experienced and communicated by victims is normal, even adaptive, and is coloured by their own active interpretations and choices" (Summerfield, 1999, p. 1454). He reports that there was no consideration of how sociocultural and situational factors can shape the outcomes of one's experience of trauma over time, and of "the limitations of Western psychiatric approaches in non-Western contexts", especially where collectivism and community is more prominent than a Western, individual worldview, or where understandings of medicine transcend the realms of just the mind and the body (Summerfield, 1999, p. 1454). Summerfield ends his critique by saying that social healing cannot be handled by outsiders to a community, as a reminder that just wanting to help is not enough – the help must be appropriate to the setting. More physicians are applying this view of non-interference in the Canadian immigration system. For example, Dr. Doug Gruner suggests waiting 3-12 months after refugees have resettled in Canada before diagnosing them with a mental health condition

(Eggertson, 2016). If symptoms of mental disorders are persistent, then once refugees are ready and looking for help, steps can be taken to provide care in a culturally competent way and facilitate access to community resources (Eggertson, 2016).

The potentially harmful effects of compressing refugee's experiences to fit diagnostic labels of mental disorders is of course an important topic to discuss and critique, and one that is ultimately outside of the scope of this thesis. I am approaching my research questions with the assumption that refugees will either have a diagnosis which pre-dates their displacement, were given a diagnosis by IME physicians while immigrating, or have identified themselves as having a mental disorder. While these assumptions are also linked to biomedical conceptualizations of mental disorders, I acknowledge that cultural differences will impact a refugee's experiences in the immigration system and could lead to particular experiences of epistemic injustice. Additionally, in my experience, much of the research which I came across related to refugees with anxiety, depression, PTSD or psychotic disorders. While these are of course very prevalent, it would be advantageous to expand the field to include conditions like autism, ADHD, OCD, mood disorders, and more. In the future, I hope that more research addresses these important topics.

I also use the terms neurodiverse and neurotypical in this thesis. The term neurodiversity was originally used in autism research by Judy Singer, an autistic social scientist, and is meant to recognize that there is diversity in how brains work. Neurodiversity recognizes that autism and other neurological conditions are natural variants, and that there is no one type of brain which should be defined as the 'normal' (Baron-Cohen, 2017). Some within the disability community feel uneasy placing minimum requirements for neurodiversity on the label, while others argue

for its use as a broadly inclusive term, one which campaigns for the full and equal inclusion of everyone (Kapp, 2020). Neurodiversity operates within and is aligned with the social model of disability. The social model of disability holds that it is not disorders or impairments which cause disability, but rather the environment that we are in which fails to accommodate for the needs of neurodiverse people (den Houting, 2018; Jaarsma & Welin, 2012). The opposite of neurodiverse, neurotypical, refers to people whose brains would be categorized as 'normal' by societal standards. I will sometimes use these terms when comparing people with mental disorders (neurodiverse) to people without mental disorders (neurotypical). This phrasing also counteracts the more medical term of mental disorder and acknowledges that mental disorders are not 'deficits', but rather naturally occurring variations of the brain.

Additionally, as a general content warning, this thesis contains mentions of rape, sexual assault, and violence. Nothing explicit is described, but it is mentioned. Please be aware of this throughout this thesis.

1.3: A Note on Hypothetical Examples

Throughout this thesis I sometimes use hypothetical examples to illustrate how refugees with mental disorders might experience epistemic injustice in the Canadian Immigration System. I recognize that my limited use of first-hand testimonies in some ways epistemically excludes refugees with mental disorders from this research. Originally, I had planned to interview refugees with mental disorders but decided against this when the COVID-19 pandemic began. Using first-hand testimony would be preferable to presenting hypothetical situations, but I have also found it difficult to find such testimony from refugees with mental disorders in the available literature. I also recognize that those who are subject to more egregious epistemic injustices

might not be able to or willing to share their experiences, as their application may have been rejected, they may be in detention, or they simply might not be comfortable sharing their experiences with a researcher. As such, I decided to include hypothetical examples with the goal of helping to illustrate how epistemic injustice might arise for refugees with mental disorders, while seeking to ensure that these vignettes are realistic. I hope that future work on this topic endeavours to center more first person testimony as I was unable to do so here.

Chapter 2: Literature Review

2.1: The Ethics of Migration

In recent years, the process of migration and issues related to migrants in general have increasingly been seen as concerns of both public and global health. Public health can be thought of as a society's efforts to promote and protect the health of the people within that society by public institutions (El-Sayed, 2016). Global health, on the other hand, is interested in improving health and health equity worldwide, with transnational research and action (Beaglehole & Bonita, 2010). Migration and its related issues can fit into two popular categorizations of public health: narrow and broad. The narrow view refers to attempts to control disease spread and influence disease prevention through traditional public health measures (such as vaccines), while the broad view takes into account other factors that impact health such as political and socioeconomic factors (Benatar & Upshur, 2011). Wild and Dawson (2018) note that migration issues and the health of migrants should be a concern for people who understand public health from within both paradigms. For those who believe in a narrow view of public health, they may see migrants as a "potential threat to the health of the host community and therefore focus on reducing the risk of communicable disease by encouraging treatment" (Wild & Dawson, 2018, p. 67). Conversely, those who take a broader view of public health understand that the health issues that refugees and migrants experience are a result of inequity in specific societies and more globally. Addressing these inequities requires promoting equity between the host and migrant communities (Wild & Dawson, 2018). Other researchers question the utility of even distinguishing between migrant health and public health (Smith, 2018). While recognizing the unique health needs of migrants helps highlight inequities in the health system, this separation can further divide migrant and citizen populations. This division can result in

migrants being cast as threats to the control of communicable diseases and as an economic burden on health systems (Smith, 2018). By understanding migrant health to be part of public health, a country's policies can be developed so that they promote better health outcomes and uphold universal human rights, promoting public health for all (Wickramage, Vearey, Zwi, Robinson, & Knipper, 2018; Wild & Dawson, 2018).

However, Wild and Dawson also acknowledge that in many cases the drivers of migration are not in the control of individual states. Forces such as climate change and conflict are both largely beyond the control of single countries, and as a result, migration will continue to be an adaption to their effects (Matlin, Depoux, Schütte, Flahault, & Saso, 2018; Wild & Dawson, 2018). These drivers and the subsequent displacement of people around the world is therefore not a single country's issue. In light of the global reach of migration, global health ethics has been suggested as a way to frame ethical concerns surrounding migration on a larger scale. Public health's concerns with migration generally focus on the ethical treatment of migrants entering a specific country. Alternatively, a global health ethics approach applies a moral value to health issues that have a more global effect (Stapleton, Schröder-Bäck, Laaser, Meershoek, & Popa, 2014). Benatar, Daar, and Singer note that in order to transition from a public health ethics view to the level of global health ethics, our interest should extend "beyond the micro-level of interpersonal relationships/individual health to include ethical considerations regarding public/population health at the level of institutions, nations and international relations" (Benatar, Daar, & Singer, 2011, p. 136). For example, moving from a question of what do we owe to refugees who are resettled in Canada, to what do we owe refugees who are currently

immigrating? Refugees who are overseas in refugee camps? And even, how can we address the root causes of health issues in refugee situations?

Whether one chooses to approach migration through the lens of public or global health, there are various ethical concerns regarding migration and the treatment of migrants. For example, whose health needs to be protected? How many resources should be set aside for migrants? What do destination countries owe to migrants? How do we determine who should be allowed into the country? These questions need to be answered in a fair and equitable way. One way to approach these questions is with the theory of cosmopolitanism, or the idea that everyone is a world citizen and that "all human beings' needs and interests deserve equal consideration" (Fabi, 2019, p. 246; Stapleton et al., 2014). Cosmopolitanism rejects geopolitical boundaries as limits for moral significance, and instead suggests that everyone has a moral duty to assist those in need regardless of nationality (Stapleton et al., 2014). The nationalism approach, which is on the other side of the spectrum, recognizes geopolitical boundaries as the extent to which our moral obligation extends (Fabi, 2019). Therefore, we only owe our support to those who are within our country (Stapleton et al., 2014).

One specific concern arises when deciding who should be allowed into the country. In Canada, this process is overseen by Immigration, Refugees and Citizenship Canada (IRCC). Throughout the immigration process, refugees must present immigration officials with their experiences and testimonials. This process becomes much more complicated if refugees are not seen as credible knowledge holders. When someone experiences an epistemic injustice, such that they are wronged in their capacity as a knowledge holder, this may impact their immigration. It also raises ethical questions surrounding how refugees experience the

immigration process. This thesis focuses on where this set of ethical issues could arise, and how these injustices can be prevented.

2.2: The Current Migration Situation Globally

The process of international migration is one that millions of people undertake each year for a variety of reasons. Some may move for a job; others may move to be with loved ones. These categories of migrants, for whom migration is motivated by study, family, or work, make up the vast majority of people migrating (IOM, 2019). On the opposite side of the spectrum, many people are forced to migrate because of dangerous living conditions or conflict. Internally displaced persons (IDPs), people who have been forced to flee their homes because of armed conflict, violence, disasters, or violations of human rights but remain in the same country, make up the majority of displaced people (UNHCR, 2020). In 2019, the Internal Displacement Monitoring Center reported 45.7 million internally displaced people, accounting for 57.4% of forcibly displaced peoples worldwide. Other types of displaced peoples includes refugees and asylum seekers, who account for 32.7% and 5.3% respectively of displaced persons worldwide. According to the 1951 Convention Relating to the Status of Refugees, a refugee is someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of persecution (UNHCR, 2010). An asylum seeker is someone who has applied for international protection but whose claim for refugee status has yet to be determined (UNHCR, 2020). While the categories of refugee and asylum seeker are smaller than others, and all displaced peoples face many hardships worldwide, refugees and asylum seekers can face unique injustices when immigrating to Canada.

Within the last decade there has been an increase in the scale of migration. The UN's Department of Economic and Social Affairs (UN DESA) estimates that the total number of international migrants worldwide was around 272 million people in 2019. This already surpassed the estimate made in 2003 that there would be 230 million migrants worldwide by 2050 (IOM, 2017). This estimate was revised in 2010 to be 405 million migrants by 2050, and while it is difficult to make these projections with high amounts of accuracy, the pattern of increasing levels of migration is likely to continue as a result of various factors (IOM, 2019). Multiple events within the last decade have contributed to the total number of refugees worldwide. The International Organization for Migration's World Migration Report points to the ongoing conflict in countries such as Yemen and the Syrian Arab Republic as drivers of migration, as well as situations of extreme violence that has forced the displacement of large numbers of people, such as violence inflicted on the Rohingya people in Myanmar (IOM, 2019). Severe economic and political instability also contributes to displacement events, as seen in the case of millions of people in Venezuela, where an intense political and humanitarian crisis has been developing for years. By the end of 2019, 4.5 million Venezuelans are estimated to have left their country due to the political crisis and the resulting poverty, lack of healthcare, and violation of human rights (Standley, Chu, Kathawala, Ventura, & Sorrell, 2020).

There has also been an increasing amount of migration due to the impacts of climate change. A still emerging field of study, much of the research so far has looked at estimates of the number of people that will be displaced. According to one study, future weather anomalies could lead to an annual displacement of 11.8 million people in sub-Saharan Africa alone by the end of the twenty-first century (Matlin et al., 2018). While it is difficult to make predictions about how

drastically climate change will affect migration, estimates range between 24 million and 1 billion people, with the most widely accepted estimate being 200 million climate refugees by 2050 (IOM, 2008). While climate change poses a threat to everyone, it has also been shown that Low- and Middle-Income Countries (LMIC), as well as disadvantaged groups in all countries, are more vulnerable to the effects of climate change (Adejuwon, 2001).

In addition to armed conflict, violence, human rights violations, and climate change, migration has been even further complicated by the current SARS-CoV-2 pandemic. When I was writing this thesis, the world was in the midst of the COVID-19 pandemic. Aside from the financial, economic, and social consequences of the pandemic, the process of migration for many people has been greatly delayed or halted. With refugees, asylum seekers, and other migrants facing travel restrictions, the status of many people's immigration process is up in the air. It is also fair to assume that this will continue to be the case for the foreseeable future. As stated in the World Migration Report 2020, "migration is in large part related to the broader global economic, social, political and technological transformations that are affecting a wide range of high-priority policy issues" (IOM, 2019, p. 1). The ripple effects of the current pandemic, compounded with other ongoing situations that influence migration, will have unforeseeable consequences on migration in the following years.

We are currently living in a time where there are both an increasing amount of drivers that push people to become refugees and asylum seekers, as well as more barriers they may face when trying to immigrate to a country. The immigration process is arduous and, as we will discuss next, requires a huge amount of disclosure regarding personal information.

2.3: The Immigration Process in Canada

As noted above, many factors may influence a person's decision to flee their country of origin (UNHCR, 2019; UNHCR, 2020). After the initial displacement event, refugees can travel through multiple countries, and take up temporary residence in either urban settings or refugee camps. They may then continue making their way to the country that they have chosen as their final destination. There is immense heterogeneity of experiences when it comes to someone's immigration journey and how long it takes. Ultimately, many are not successful in reaching the destination country. A true example of someone's refugee journey is Gulwali Passarlay, the author of *The Lightless Sky*. Gulwali was 12 when he left Afghanistan and became a refugee, and even though only a year passed by the time he reached his final destination in the United Kingdom, he had travelled through ten countries and multiple refugee camps to get there (Passarlay, 2016).

When entering the Canadian refugee program, people outside of Canada can apply to the Refugee and Humanitarian Resettlement Program (Canada, 2019g). They must be identified and referred by either the UNHCR, a private sponsor, or a community group sponsor. Without a referral from an organization or sponsor, a person is not eligible to apply as a convention refugee to Canada (Canada, 2020c). After being referred, applicants must be deemed eligible to apply in the category of Convention Refugee Abroad Class or Country of Asylum Class. If an applicant has another option for protection (i.e. they have been granted refuge in another country), becomes a citizen of another country, chooses to return to the country they left, or their reason for leaving no longer exists (i.e. the civil war that forced their displacement ends), then they are not eligible to apply (Canada, 2019g). In most cases, an interview with a migration officer is required,

where the officer determines whether applicants meet Canada's eligibility and admissions criteria (Canada, 2018a). These interviews serve to "elicit detailed family composition and background information, ask statutory questions, obtain authorizations that are not included in the UNHCR Resettlement Registration Form (RRF), and collect biometrics" (Canada, 2018a, p. 7). If the applicant meets the eligibility criteria, their cases are processed and they undergo a screening process to ensure that "there are no issues related to security, criminality, or health" for those entering the country (Canada, 2019c). The 'principal applicant' of the family must then fill out numerous forms for themselves and all family members, as well as forms detailing the backgrounds of all family members who are above 18 years of age (Canada, 2020c). Photos are required as part of the application, as well as identity and civil status documents, children's information, background documents, travel documents and passports when possible (Canada, 2020c). If these forms and documents are not written in English or French, a translation must be provided, along with an affidavit from the person who completed the translation and a copy of the original document (Canada, 2020c).

In addition to background checks and detailed disclosure of the events leading to the applicant seeking protection as a refugee, an IME is required. The IME must be conducted by a 'panel physician', who is a physician specifically approved by the Canadian government to administer the IME (Canada, 2018b). A person is evaluated based on their perceived risk to public health, public safety, and whether they will place excessive demand on health or social services (Canada, 2019e). For public health considerations, having an infectious disease such as active tuberculosis, syphilis, or being in close contact with someone who has an infectious disease, is taken into account and could lead to the applicant being refused entry to Canada

(Canada, 2018c). In regard to public safety, the risk of sudden incapacity (defined as loss of physical and mental abilities), or unpredictable or violent behaviour, is also taken into consideration (Canada, 2018c). Finally, if treatment of a condition could potentially prolong wait times for services in Canada or would cost more than the excessive demand threshold, then an applicant may be deemed inadmissible (Canada, 2018c)[2]. The excessive demand criteria does not apply to Convention refugees or other people granted refugee or protected status within Canada. However, those exempt from this criteria are still assessed for a danger to public health or public safety (IRCC, 2020). If a person is deemed medically inadmissible, they will be sent a procedural fairness letter detailing why they have been considered inadmissible. They can then respond to this letter before the final decision is made, providing any information that may influence the decision. This process is summarized in Figure 1 at the end of this section.

People within Canada with a well-founded fear of persecution or who are at risk of harm if they return to their home country can apply to the In-Canada asylum program if they are eligible to do so (Canada, 2019a). While the convention refugee path can be described as an administrative process, the asylum program is a quasi-judicial process in that it features the refugee claimant, an IRB member, and potentially their counsel or a representative of the CBSA or IRCC, where the claimant is questioned about their claim for asylum (Canada, 2018a). Many asylum seekers cross the border into Canada irregularly, as opposed to refugees who are already permanent residents by the time they arrive in Canada (Canada, 2019a). In the case of crossing the border illegally, asylum seekers intercepted by law enforcement are escorted to the nearest

[2] The excessive demand threshold is calculated to be three times the Canadian average cost for health and social services, and was determined to be $20,517 per year in 2019 (Canada, 2018c).

Canadian Border Services Agency (CBSA) port of entry where an officer conducts an immigration examination. During this examination, health checks to address any immediate health needs are conducted. The individual also undergoes a security screen consisting of biographic and biometric checks to ensure they do not pose a security threat to Canada (Canada, 2019a). It is also determined whether or not detention is required. At this point, a refugee claim may be initiated if it is deemed necessary. If the person's claim is deemed eligible then they will be referred to the Refugee Protection Division (RPD) of the IRB for a hearing.

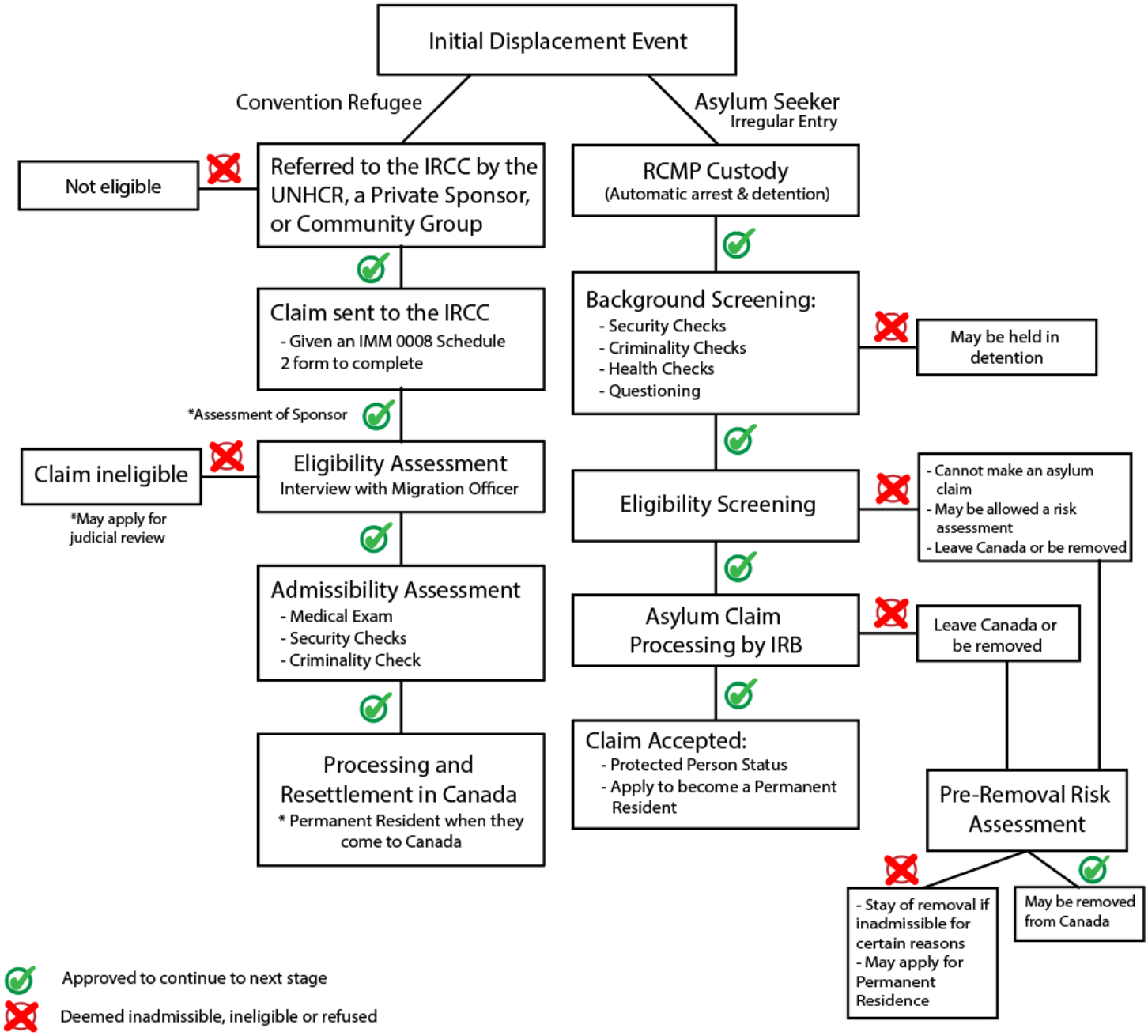
Another reality of the immigration process is that asylum seekers may be placed in detainment centers (von Werthern et al., 2018). Migrants who attempt to cross borders illegally, refugees or asylum seekers who are going through the immigration process, or people who have been flagged by the authorities as someone who will be refused protection can be held in detainment centers (von Werthern et al., 2018). The length of time that a person is detained can vary widely. The average duration is around one month, but for some detention can span multiple months (Nair, 2019). Close examination of the reasons for a person's detention has shown that in many cases, the decision to detain someone is not strongly supported by evidence. Only 6% of detained asylum seekers are held due to a suspicion of criminal activity. Most people are detained on the grounds that they were deemed to be unlikely to appear for hearings or examinations, with this number reaching 3579 people in 2015 (Canadian Council for Refugees [CCR], 2016b). The second most likely cause was people being judged to be "dangerous and unlikely to appear", with the CBSA detaining 340 people based on such an assessment in 2015 (CCR, 2016a). Arrest or detention of a foreign national (who is not considered to be a protected person) is permitted without a warrant when the officer has "reasonable grounds to

believe [that person is] inadmissible and is a danger to the public or unlikely to appear for examination, an admissibility hearing, or removal from Canada" or if the officer is not satisfied with the foreign national's identity (Canada, 2001; Nair, 2019). This would come into play for asylum seekers who are claiming protection and those who cross the border illegally.

If at any point throughout this process an asylum seeker receives a negative decision in their attempt to immigrate, they have a few available options to pursue to stay in Canada. They may apply for a pre-removal risk assessment, where an officer assesses whether removal would put the claimant in danger of torture, persecution, risk to their life, or of cruel and unusual treatment and punishment (Canada, 2020d). Refused claimants can also appeal to the Refugee Appeal Division (RAD) of the IRB within 15 days of receiving their decision, or before the Federal Court (Canada, 2019f). During this time they may be held in detention facilities. Failed asylum seekers, even those who are going through the appeal process, will be issued a removal order.

As seen in this overview, the process of immigrating to Canada can be a long and arduous one, placing much of the onus on the applicants themselves. Whether it is filling out a large number of highly detailed forms, travelling to the IME, enduring detention, or navigating legal proceedings, refugees and asylum seekers must face the brunt of this process on their own. For the people in these populations who have a mental disorder, this process is likely to be even more difficult as they have to balance their well-being and how they are perceived by others with completing their immigration process.

2.3.1: Figure 1 - The Immigration Process



2.4: Prevalence of Mental Disorders in Refugees

Estimates surrounding the prevalence of mental disorders within the global population and the refugee population vary widely. The World Health Organization (WHO) has estimated that about 15% of the world's population lives with some form of disability, including a physical disability or mental disorder (World Health Organization & World Bank [WHO & WB], 2011). There is also strong evidence of unequal distribution of disability around the world. A World Health Survey conducted in 2011 indicated that higher levels of disability (both physical and mental disorders) exist in lower income countries (WHO & WB, 2011). This number may be even higher among people who have been displaced because of violence or natural disasters, with that prevalence rising to approximately one in five people (22.1%) in conflict settings (Chisholm et al., 2016; Women's Commission for Refugee Women and Children [WCR], 2008). One estimate puts the percentage of refugees and asylum seekers who experience mental disorders as high as 66.6% (Khan & Amatya, 2017). While estimates vary greatly across contexts and depending on the ways they are generated, there is compelling evidence suggesting increased prevalence of mental disorders in refugee populations.

Recent research has shown that the causes of mental disorders are multifactorial, linked to both genetic and environmental factors (Borsboom, 2017; Kendler, 2012; Schmidt, 2007). Whether a person has a mental disorder is not just based on their genetic predisposition, but also on their lived experiences. Some of these environmental exposures may also be strong enough to bring about the onset of a mental disorder. In short, what a person experiences in their lifetime will have an effect on their mental health (Schmidt, 2007). This feature of mental disorders suggest that refugees may be even more susceptible to developing them, or having

pre-existing conditions worsen. A refugee's experiences of the events that prompted their displacement, as well as the process of immigrating to an entirely new country, may lead to them developing a mental disorder. Khan and Amatya note that "[refugees] arrive from different countries and cultures with complex health needs, and many experience trauma before, and during their deleterious journeys" (Khan & Amatya, 2017, p. 378). In turn, these disorders may contribute to making the immigration process more challenging to navigate. Any issues they encounter could have a compounding effect, along with their disorder and earlier trauma, and create a positive feedback loop.

Another issue that arises when trying to quantify the number of refugees with mental disorders is that they are not identified or counted in registration data in refugee camps. Refugees with mental disorders are much less likely to be identified as having these conditions since they "[tend] to be more 'invisible' and 'hidden' from public view than those with physical disabilities" (WCR, 2008, p. 2). Part of why refugees with mental disorders may be overlooked by the staff in refugee camps could be due to intentional efforts to avoid detection. Stigma and potential negative consequences that may result from being labelled with a mental disorder are major deterrents for people seeking help (Griffiths, Crisp, Barney, & Reid, 2011). There also may be cultural differences in how mental disorders are perceived. For example, in Latin American countries mental disorders are closely tied to the concept of *familismo*, where stigma can originate from not being able to contribute to the family (Mascayano et al., 2016). In some cases, religious beliefs can create stigma, for example, the belief that a person with a mental disorder is possessed by the devil or lacks faith (Ran et al., 2021). Such factors influence whether refugees with mental disorders divulge that they have a mental disorder. Not divulging this information

results in refugees with mental disorders receiving less information and support services than those with physical or sensory disabilities. It also contributes to exclusion from assistance programs and decision making or leadership roles (WCR, 2008). While the problem of identifying refugees with mental disorders is difficult in the setting of a refugee camp, it can be even more difficult in an urban setting. This is because urban refugees are often undocumented and lack legal status, and as a result cannot access supports without the fear of being detained by authorities (WCR, 2008).

Another issue that makes it more difficult to quantify mental disorder rates among refugees is that they are less likely to disclose that they have a mental disorder during or soon after they immigrate. These cases, where refugees initially do not disclose mental disorders but do so in the years following their immigration, are in line with research surrounding the 'healthy immigrant effect'. While it was originally believed that immigrants in general were healthier than the average Canadian population upon their immigration, research revealed that this health benefit disappeared in the years following their immigration (Newbold & Danforth, 2003; Ng, 2011; Perez, 2002). Newbold and Danforth looked at all types of immigrants (rather than just refugees) and found that within 5 to 10 years immigrants' health was similar to that of the Canadian average (Newbold & Danforth, 2003). The authors link this decrease in health to various sources, such as lower income groups being less resilient in the face of system restructuring, immigrant populations being less trusting of a medical system, or even a medical system that does not provide adequate care.

Newbold's follow up 2009 study examined Statistics Canada's Longitudinal Survey of Immigrants to Canada (LSIC) in order to gauge the health of newly arrived immigrants to Canada.

He divided immigrants into three categories (economic, family and refugee) and proceeded to examine how they ranked their health at three time points, six months after arrival, two years after arrival, and four years after arrival. The results showed that within two years of arrival the average number of refugees reporting mental health problems increased from 5.1% to 28.5%, and that on average refugees were more likely to report poorer overall health than any other migrant class (Newbold, 2009). Newbold posited that this could be attributed to the increased vulnerability of this population, with refugees having more health risks because of their traumatic experiences and the resettlement process. Unfortunately this is the only study that directly compared the health of refugees to other immigrant classes in Canada, and as such it is not possible to corroborate these results. However, this does suggest that many refugees who immigrate to Canada have a mental disorder, whether it is recorded or not.

Various studies have suggested that certain mental disorders are present at higher rates in refugee populations (Bhui et al., 2006; Bogic et al., 2012; Jamil et al., 2002; Keyes, 2000). One such disorder is PTSD. People who experience trauma have a 30-50% chance of developing PTSD, and when that trauma is more severe, the likelihood of developing PTSD raises to nearly 100% (Schmidt, 2007). Systematic reviews of existing literature show that the percentage of refugees with PTSD in Western countries (in this case, the United States, Australia, Netherlands and Sweden) could be as high as 37.2%, while depression could be as high as 75% (Khan & Amatya, 2017; Slewa-Younan, Uribe Guajardo, Heriseanu, & Hasan, 2015). A study conducted in Germany by Georgiadou, Morawa and Erim found that in comparison to the general German populations, asylum seekers reported much higher rates of distress and mental disorder. While only 2.9% of the general German population showed symptoms of PTSD, symptoms appeared in 35.7% of

asylum seekers (Georgiadou, Morawa, & Erim, 2017). This trend of higher PTSD levels among refugees has also been supported by other studies (Fazel, Wheeler, & Danesh, 2005; Kirmayer et al., 2011). The study also observed high levels of depression and anxiety (57.1% and 39.3% respectively) (Georgiadou et al., 2017). Fazel et al's systematic review of interview-based psychiatric surveys of refugee populations in Western countries (Australia, Canada, Italy, New Zealand, Norway, the UK, the US) suggested refugees were about ten times more likely to have PTSD than the age matched general population (Fazel et al., 2005).

Another example is psychotic disorders such as schizophrenia, with research showing that migration and its stressors increase the likelihood of developing this disorder (Kirkbride et al., 2012; Morgan, Charalambides, Hutchinson, & Murray, 2010). Other studies have also shown that psychotic disorders, which are a subset of mental disorders, also have elevated rates of occurrence in refugees. Kirkbride and Hollander studied the incidence of psychotic disorders in refugees entering Canada and found that there were higher rates of these disorders among refugees from East Africa and South Asia (95% and 51% increased risk respectively) than in the general Canadian population (Kirkbride & Hollander, 2015). While this increased incidence was not seen in refugee populations from other regions of the world, the authors acknowledged that this could be because their study had limited power to detect an increase of significance. They also note that the rates of psychotic disorders were not increased in non-refugee migrants (Kirkbride & Hollander, 2015). Although these are preliminary results which require further investigation, they suggest that the refugee population is particularly susceptible to the development of psychotic disorders such as schizophrenia, as a result of "exposure to traumatic events before migration… social, cultural and economic hardships following migration… including

stresses induced by the asylum process itself" (Kirkbride & Hollander, 2015, p. 637). Another study conducted by Anderson et al. found increased prevalence of schizophrenia and schizoaffective disorder in refugee populations. In comparison to the general Canadian population rate of 55.6 per 100,000 people living with schizophrenia or schizoaffective disorder, and 51.7 per 100,000 people for immigrants, the prevalence amongst refugees was 72.8 per 100,000 people (Anderson, Cheng, Susser, McKenzie & Kurdyak, 2015). Based on this data, they argue that "the mental health status of immigrants and refugees should be a national priority" (Anderson et al., 2015, p. 285).

Refugees are also more likely to show symptoms of depression and anxiety. Hameed et al.'s review of the higher rates of mental disorders in refugees suggested that the traumas they experience before, during, and after their migration are a factor. One main stressor which negatively impacted refugee's mental health was acculturation (Hameed, Sadiq, & Din, 2018). Acculturation is described as "the process of integrating into a new culture while also maintaining one's origin culture and identity" (Hameed et al., 2018). This struggle to balance one's identity while also attempting to integrate into society is one that refugees may experience when immigrating to a new country. The stress of acculturation on top of the stress that can come from simply living in a foreign country, such as difficulty understanding the language, difficulty getting a job, and facing discrimination, thus contributes to long-term experiences of mental disorders. Another distinction of the trauma that refugees and asylum seekers face is the presence of secondary features. The DSM-V refers to secondary psychotic features as a psychotic disorder due to another medical condition, which includes prominent hallucinations or delusions which are a direct pathophysiological consequence of another medical condition (APA, 2013).

For refugees with PTSD there was a 41% occurrence rate of secondary features (PTSD-SP) (Hameed et al., 2018). These features increase the burden of a refugee's disorder and potentially impacts how people perceive them. Thus, in addition to higher rates of PTSD, anxiety and depression, refugees are also more at risk of experiencing reality-altering secondary features of disorders.

Many events that precede a refugee or asylum seeker's immigration to Canada can contribute to mental disorders and trauma. This is also true of certain aspects of the Canadian immigration system. It has been well documented that even short periods of time in detention have a significant impact on the wellbeing of refugees and can impact the severity of mental disorders and the development of new ones (Gros & van Groll, 2015). In Immigration Holding Centers where asylum seekers are detained, primary health care is provided but mental health services are not (J. Cleveland & Rousseau, 2013). Cleveland and Rousseau's research on this topic in 2013, which was the first to compare detained and non-detained asylum seekers, found that there were significantly higher levels of symptoms of depression, anxiety and PTSD in the detained group (J. Cleveland & Rousseau, 2013). A follow-up study by Cleveland et al. (2018) further demonstrated both the short and long term effects of detention. They found that "after a median detainment of only 18 days, lower than the average detention length in Canada, detained asylum seekers were almost twice as likely as their non-detained peers to experience clinical levels of PTSD symptoms (32% vs 18%)", and that they were 50% more likely to have clinical levels of depression (78% vs 52%) (Cleveland, Kronick, Gros, & Rousseau, 2018, p. 1005). The authors link this dramatic increase of symptom severity to the symbolic violence that asylum seekers face, as well as disempowerment that they feel while detained. Symbolic violence refers

to measures which signal to asylum seekers the denial of many of their basic human rights and freedoms for an indeterminant amount of time, such as being handcuffed and transported in a police van (Cleveland et al., 2018). These experiences can compound pre-existing traumas or vulnerabilities, and further exacerbate the impact of detention on asylum seekers with mental disorders (Cleveland et al., 2018). While there are many things that are outside the control of the Canadian government in regard to the trauma that refugees or asylum seekers experience, detention practices, which have been shown to contribute to the development and worsening of mental disorders among refugees and asylum seekers, are certainly within governmental control.

Many researchers stress that this is still an emerging field of study which requires more investigation (Hameed et al., 2018; Khan & Amatya, 2017; Newbold, 2009). Overall, the available literature suggests that there are higher levels of mental disorders among refugee and asylum seeker populations.

Chapter 3: Epistemic Injustice as a Framework for Analysing the Canadian Immigration System

The following is a first-hand account from a female asylum seeker with a mental disorder, which was recorded by Cleveland, Guzder & Rousseau in their 2014 paper *Cultural Consultation with Refugees:*

> Begum was a 30-year-old Bangladeshi Muslim mother who had fled her country after repeated domestic violence. After she had attempted to leave her husband, he abducted her from her family, vandalized her parent's home, and assaulted them. With the help of her parents, she left Bangladesh with her 4-year-old son. En route to Canada, she was detained in New York by the agents who had arranged her passage with her parents. She was taken to an apartment with other refugees and raped before being returned to the airport.
>
> She applied for refugee status in Canada but was too ashamed to recount her rape en route and the history of rape within her marriage. The refugee board rejected her claim because her testimony differed from her initial written claim, and she had dissociated during the hearing when attempting to recount her traumatic journey. Her appeal process continued for 6 years. During much of this time, she was suicidal and depressed, at times threatening to kill both her children as she felt unsafe to return to Bangladesh where he husband continued to be involved in antisocial gang activities. She was particularly terrified that she might be returned to New York, which triggered re-experiencing of her rape and helplessness. Both her parents died in Bangladesh during this period and this further complicated her adaptation. Her depression undermined her parenting capacity and her children also suffered from depression.
>
> … Initially, she had been assessed by a male Euro-Canadian psychiatrist and refused to speak because cultural and gender differences precluded a sense of cultural safety. Her primary care team, comprised of a female general practitioner and social worker, worked with interpreters, her children's school, the Department of Youth Protection, and other resources to stabilize her functioning. Her functioning improved significantly after her refugee status was confirmed, but her children remained fragile and continued to have significant mental health problems.
>
> (Cleveland, Rousseau, & Guzder, 2014, pp. 256-257)

3.1: Epistemic Injustice

Epistemic practices are defined as "the socially organized and interactionally accomplished ways that members of a group propose, communicate, access, and legitimize knowledge claims" (Kelly & Licona, 2018, p. 139). We undertake epistemic practices everyday, such as when we are teaching a family member how to make a recipe, or when we reflect with our friends on social movements, our involvement in them and how we can further contribute. In epistemic exchanges between a speaker and a listener, one can normally expect that they regard each other as equally deserving of respect and credibility. However, if a speaker's knowledge is dismissed because of a prejudice that a listener holds against them, or when there are insufficient collective resources for the speaker to make sense of their social experiences, the speaker is subjected to an epistemic injustice. Injustices that arise from differences in epistemic relations are highly relevant when examining how epistemic trust (or whose knowledge we trust) is related to social power. They are also connected to how social disadvantage can produce unjust epistemic disadvantage (or decreased respect of knowledge or knowledge production) (Fricker, 2007). Epistemic injustice is closely related to the concepts of equity and power. As these issues are highly relevant to the experiences of refugees with mental disorders, I will utilize epistemic injustice as the conceptual framework to orient the analysis presented in this thesis.

Miranda Fricker's 2007 book *Epistemic Injustice: Power & the Ethics of Knowing* was the first to systematically describe and fully develop a theory of epistemic injustice. However, there is a long history of scholars discussing related concepts. Epistemic violence and interpretive silence are described as far back as 1892 by Anna Julia Cooper when discussing how Black women's ideas are suppressed, and in 1867 Sojourner Truth discussed how Black women are

afforded less credibility as knowers (Pohlhaus, 2017). Gayatri Chakravorty Spivak also mentions epistemic violence in her 1988 article *Can the Subaltern Speak.* Spivak discusses two classes of people, those who have some form of privilege, and those who do not. Those who do not are who she calls 'subaltern peoples' (Spivak, 1988). Spivak describes epistemic violence as a result of the people in power claiming to know the interests of subaltern peoples, even when those claims are made before the subaltern people can make their own claims (Spivak, 1988). Thus, the practice of identifying and calling out epistemic power imbalances is not new, and much is owed to the women of colour scholars who were pioneers of this theory.[3]

Fricker's book *Epistemic Injustice: Power & the Ethics of Knowing* focuses on two fundamental epistemic practices central to everyday life: conveying knowledge to others and understanding our own social experiences. These two practices are often influenced by "the operation of social power in epistemic interactions", but have been largely overlooked in the field of epistemology (Fricker, 2007, p. 4). Fricker's aim is to illuminate the ethical aspects of these actions, so that we can "trace some of the interdependencies of power, reason, and epistemic authority" and see how our conduct might become more rational and just in epistemic spaces (Fricker, 2007, p. 4). Epistemic injustice is broadly defined as a wrong committed against someone specifically in their capacity as a knower. The two main forms of epistemic injustice that Fricker identifies are testimonial injustice and hermeneutical injustice.

[3] While it is tempting to state that Fricker was the first to precisely articulate epistemic injustice, it is also imperative to recognize the epistemic labour of those who came before her, both named and unnamed, who worked against epistemic injustice and laid the groundwork for current discussions. By saying that Fricker was the 'creator' of epistemic injustice, we not only perpetuate the ignorance of those who have historically called attention to epistemic injustice, but also exploit their epistemic labour in order to further our own endeavours.

Testimonial injustice occurs at the individual level when "prejudice on the hearer's part causes [them] to give the speaker less credibility than [they] otherwise would have given" (Fricker, 2007, p. 4). The key attribute of a testimonial injustice is that the hearer has a prejudice. Prejudices in this case are judgements which may have a positive or negative effect on the beliefs of those who hold them (Fricker, 2007). Prejudices are not automatically negative. However, in the case of testimonial injustice, a negative prejudice leads to disparaging associations between a group and attributes, where this association "embodies a generalization that displays some… resistance to counter evidence owing to an ethically bad affective investment" (Fricker, 2007, p. 35). Essentially, these negative prejudices cause the listener who holds them to think less of a speaker who exhibits these characteristics. Take for example the scenario described at the beginning of this chapter. In it, a testimonial injustice is experienced by Begum, an asylum seeker with a mental disorder. It arises because of the prejudice that the IRB member has regarding her behaviours, which are symptoms of her PTSD and depression. Specifically, because her testimony was different from her initial written claim, and because her traumatic experiences caused her to dissociate, the IRB member assigned less credibility to her testimony. Because of the symptoms of her mental disorder, Begum is seen as less credible in the eyes of the IRB member. [4]

In contrast to the individual interactions displayed in testimonial injustice, hermeneutical injustice stems from more society-level deficits of shared tools for social interpretation.

[4] I found Kukla's 2014 paper *Performative Force, Convention and Discursive Injustice* very helpful in understanding epistemic injustice. Her work defines speech acts and discusses the linguistic underpinnings of discursive injustice (her phrase for testimonial injustice) and epistemic injustice overall.

Hermeneutical injustice is when "a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker, 2007, p. 1). Fricker notes that this form of injustice occurs at a prior stage; it is not a single person's prejudice that causes the injustice, but rather society's communal lack of understanding that does. To explain this concept, Fricker quotes from Nancy Hartsock, "The dominated live in a world structured by others for their purposes – purposes that at the very least are not our own and that are in various degrees inimical to our development and even existence" (Hartsock, 1998, p. 241). The word 'structured' can have different meanings, but Fricker focuses on the epistemological one, which suggests that people in positions of power in society have an unfair advantage when it comes to structuring collective social understandings. This means that while society's shared understanding of topics should reflect the perspectives of all social groups, the powerful group has sufficient interpretive resources available which makes them able to better understand their experiences. Conversely, the socially disenfranchised or less powerful group look at their experiences "through a glass darkly, with at best ill-fitting meanings to draw on in the effort to render them intelligible" (Fricker, 2007, p. 148). The primary harm of hermeneutical injustice can be called a *situated hermeneutical inequality*, where a person's social situation "is such that a collective hermeneutical gap prevents them in particular from making sense of an experience which it is strongly in their interests to render intelligible" (Fricker, 2007, p. 7).

One example of hermeneutical injustice that Fricker presents is in relation to post-partum depression. It was only through women hosting 'speak-outs' and sharing their experiences, which had previously never been discussed between women let alone in society at large, that they were able to understand their experiences of depression after giving birth was

not a failing of themselves, but an actual physiological condition (Fricker, 2007). One hypothetical example of hermeneutic injustice that I will present in more depth later is of a male refugee with PTSD. His PTSD is a result of sexual assault, and he is trying to explain his experiences and symptoms to an IME physician. Because of the stigma surrounding male sexual assault, both physicians and patients alike avoid these discussions. Even the language that men can use to describe their experiences of sexual assault has been poorly developed (Wedi, 2018). Thus, there are fewer hermeneutic resources available for men when trying to express their experiences of sexual assault. In the IME, this could lead to a male refugee being ill equipped to explain why he is unwilling to undergo a physical examination. As a result, he might be deemed ineligible to immigrate to Canada.

Fricker also discusses how through practicing testimonial justice and hermeneutical justice, it is possible for a person to be epistemically just. Testimonial justice is the correcting of one's own prejudices in credibility judgements reliably over time, whereas hermeneutical justice occurs when a hearer reflects on what they find unintelligible because of a gap in hermeneutic resources, and adjusts or suspends judgement accordingly (Fricker, 2007). Building on Fricker's work, LeBlanc and Kinsella define epistemic justice as a "reflexive awareness on the part of ordinary, but epistemically sensitive, listeners... [who engage in] self-criticism and openness to changing negative patterns of credibility judgement and interpretive habits, so that the unprejudiced perception of another human being might transcend deeply entrenched negative identity prejudices and stereotypes" (LeBlanc-Omstead & Kinsella, 2016, pp. 72-73). Practicing epistemic justice is not easy, as it requires a level of self-reflection that many people may not be prepared to commit to. However, in order to ensure that everyone is treated as epistemic

equals, it is necessary to identify our own biases, and work to counteract them both on the interpersonal level and on the structural level.

3.2: Further Developments Related to Epistemic Injustice

Following Fricker's development of a theory of epistemic injustice, other philosophers and theorists have expanded on the initial concepts[5], including notions of epistemic violence, epistemic privilege, epistemic oppression, and epistemic exclusion[6].

Although epistemic violence was first mentioned by name by Spivak in 1988, it is more broadly discussed in Kristie Dotson's 2011 work *Tracking Epistemic Violence, Tracking Practices of Silencing*. Dotson defines epistemic violence as the "failure of an audience to communicatively reciprocate, either intentionally or unintentionally, in linguistic exchanges owning to pernicious ignorance. Pernicious ignorance is a reliable ignorance that, in a given context, is harmful" (Dotson, 2011, p. 242). One way in which this form of epistemic injustice can be used is to damage a specific group's ability to speak or to be heard, in other words silencing that group. Dotson's first example of how epistemic violence can be used to silence a group is *testimonial quieting.* This form of epistemic violence occurs when "an audience fails to accurately identify the speaker as a knower, thereby failing to communicatively reciprocate in a linguistic exchange due to pernicious ignorance in the form of false, negative stereotyping" (Dotson, 2011, p. 243). This type of silencing has been discussed in detail in the work of women of colour such as Dr. Patricia Hill Collins. Her research describes how Black women are viewed as less credible because

[5] All the concepts that I discuss, as well as their definitions, can be found at the end of this chapter in table 1.
[6] Again, while some of these concepts can be seen in academic writing by women as early as 1867, they have been further developed since the release of Fricker's book. I will be focusing on more contemporary publications but want to make it clear that the work done by early academics is of critical importance to the formulation of the theory of epistemic injustice.

of their audience being unable to "discern the possession of credibility beyond 'controlling images' that stigmatize Black women as a group" (Dotson, 2011, p. 242). A set of stereotypes about Black women, including the archetypes of mammy, matriarch, welfare mother, or whore, serve to make the unfair treatment and negative assessments of black women appear "natural, normal, and inevitable parts of everyday life" (Hill Collins, 2000, p. 69). Because of these stereotypes Black women are seen as less competent than others and unable to contribute to epistemic communities, resulting in experiences of testimonial quieting.

The second form of epistemic violence Dotson discusses is t*estimonial smothering*, where "because the speaker perceives one's immediate audience as unwilling or unable to gain the appropriate uptake of proffered testimony… [they truncate their] own testimony in order to ensure that the testimony contains only content for which one's audience demonstrates testimonial competence" (Dotson, 2011, p. 244). An example that Dotson gives for this form of epistemic violence is in relation to Kimberlé Crenshaw's work on domestic violence in the Black community. Within the African American community, there can be a hesitancy for people to report instances of domestic violence or domestic abuse, because of the possibility that this could reinforce negative stereotypes of the 'violent' Black male (Dotson, 2011). In many ways, engaging in respectability politics is a form of epistemic violence, as minority communities must present their experiences or arguments in a way that is palatable by the majority, which is in many cases the white community.

In both of these situations a person's knowledge is either dismissed or is not acknowledged as worthy of recognition. As a result, they suffer an epistemic violence. There are many situations in which a refugee with a mental disorder may experience silencing due to

epistemic violence. For example, in Begum's story, as a female asylum seeker with PTSD and depression who is sexually assaulted, she feels the need to leave the details of her assault out of her testimony. Because she believes that the immigration officials will not understand or believe her story of assault, Begum smothers her own testimony to make it more palatable for the IRB member. Epistemic violence can have a dramatic impact on how the testimony of a refugee with a mental disorder is presented and received, and as such it is important to identify these instances so that we can learn how to better support refugees with mental disorders throughout the immigration process.

Dotson further contributes to the development of epistemic injustice by articulating the concepts of epistemic oppression and epistemic exclusion. Epistemic exclusion is defined as an unwarranted infringement on the epistemic agency of knowers, or their ability to utilize shared epistemic resources effectively in order to participate in knowledge production or revision (Dotson, 2014). Dotson uses the concept of epistemic exclusion to explain epistemic oppression which she defines as a "persistent and unwarranted infringement on the ability to utilize persuasively shared epistemic resources that hinder one's contributions to knowledge production" (Dotson, 2014, p. 116). These concepts point to certain groups being denied credibility, which thus impacts their ability to contribute to an epistemic community. It is not difficult to imagine that this could be the case for some refugees with mental disorders, where because of epistemic oppression they cannot contribute to policy production or knowledge pooling.

An additional concept related to epistemic injustice is epistemic privilege. Epistemic privilege has been described as occurring when one group or person's knowledge is valued more

than another's. For example, psychiatrists and other healthcare professionals evaluate their patients' testimonies and decide which aspects are important to considered and which can be ignored (Kurs & Grinshpoon, 2018a; Wardrope, 2015). Epistemic privilege results in certain voices being ignored in favour of other groups whose voices are deemed more credible.

There has also been development of concepts regarding epistemic justice. In addition to testimonial and hermeneutical justice, epistemic humility has been developed as a way to work against epistemic injustice. Wardrope defines epistemic humility as "an attitude of awareness of the limitations of one's own epistemic capacities, and an active disposition to seek sources outside one's self to help overcome these shortcomings" (Wardrope, 2015, p. 350). In addition to the private awareness of this limitation, there must also be a public expression of one's epistemic limitations in order to challenge the collective lack of conceptual resources (Wardrope, 2015). Finally, epistemic humility requires that people who have epistemic privilege not extend their claims of expertise beyond their legitimate boundaries, and that "they engage with different perspectives where those may be relevant to their inquiries" (Wardrope, 2015, p. 350).

3.3: Critiques of Epistemic Injustice and Alternatives

While there have been many developments in the theory of epistemic injustice, there have also been alternatives suggested as well as critiques. Corwin Aragon suggests an alternative approach in *Global Gender Justice and Epistemic Oppression*, one that is more structural as opposed to individual. Aragon conceptualizes testimonial injustice as the "epistemic processes that systematically discount the testimony of members of some social groups while privileging the testimony of other, related social groups", rather than an injustice which is based on a hearer's prejudice (Aragon, 2019, p. 18). Similarly, hermeneutical injustices arise from "epistemic

processes that systematically constrain members of some social groups in the development and exercise of their hermeneutical capacities while at the same time privileging the hermeneutical practices of members of some other, related social group", as opposed to how one person is harmed by not understanding their experiences (Aragon, 2019, p. 18). Rather than focusing on the individual removed from the societal context, Aragon views epistemic injustices as harms against members of specific social groups as a result of the epistemic relations between groups.

There are also critiques regarding how the theory of epistemic injustice itself ignores the knowledge of minority groups. For Rebecca Mason, a gap can be found in the definition of hermeneutical injustice where Fricker does not account for the possibility that "marginalized groups can be silenced relative to dominant discourses without being prevented from understanding or expressing their own social experiences" (Mason, 2011, p. 294). Mason argues that Fricker fails to acknowledge the epistemic practices of non-dominant subjects in her work, and as a result contributes to their marginalization and disempowerment. By equating the 'collective' knowledge resources with that of the dominant group, Fricker ignores knowledge resources that are held by marginalized peoples. Mason points out that this ignores the possibility that "knowledge practices among members of more powerful groups can produce and maintain distorted understandings of the social experiences of marginalized groups despite contrary, and arguably better, interpretations that fail (through systemic hermeneutical marginalization) to gain voice in dominant discourses" (Mason, 2011, p. 300). Non-dominant hermeneutical resources are available for marginalized subjects to understand their experiences, but the ignorance of dominant groups towards these resources leads to hermeneutical injustices.

Beeby also argues that Fricker's main example of a hermeneutical injustice does not rely on an injustice that is strictly epistemic. Fricker's example of Carmita Woods and her experience of sexual harassment does not hold up, Beeby argues, because Carmita and her harasser are both subject to hermeneutical injustice. Neither of them have the resources to understand gender roles in the workplace, and as a result, the harasser takes advantage of Carmita's vulnerable position and harasses her, inflicting harm on Carmita but not on himself (Beeby, 2011). Beeby asks the questions "would the harasser's behaviour have been different if he had a sufficient understanding of gender roles in the workplace?" and "was his social privilege responsible for putting him in an epistemic position of ignorance and false confidence?" (Beeby, 2011, p. 484). These questions are not to excuse the harassment, but rather to bring to attention that both people in this situation lacked knowledge in terms of gender roles and power structures in their work environment. Beeby then suggests that we move away from relying on social conditions to explain hermeneutical injustice, and instead should keep "the loss or privation of epistemic goods and skills at its heart" (Beeby, 2011, p. 485). Thus, hermeneutical injustice becomes more about the gain and loss of epistemic privileges, and less about pre-existing social concepts around them.

Despite these valid critiques, the theory of epistemic injustice is a useful lens for examining knowledge, power structures and marginalization within our society. As I discuss next, these are just some factors that make epistemic injustice a fitting framework for this project.

3.4: Why use Epistemic Injustice for this project?

As previously mentioned, epistemic injustice is a useful theory to examine issues that occur at the intersection of power and equity. This section will discuss why people with mental

disorders may be even more vulnerable than neurotypical people to epistemic injustice. Carel and Kidd note that those who are ill are even more vulnerable to epistemic injustice "through the presumptive attribution of characteristics of unreliability and emotional instability that downgrade the credibility of their testimonies" (Carel & Kidd, 2014, p. 529). They discuss how in healthcare settings patient testimonies are often dismissed as unimportant or too emotional. Even if the patient's testimony is clear and straightforward, if it "is not expressed in the accepted language of medical discourse [it] will therefore be assigned a deflated epistemic status" (Carel & Kidd, 2014, p. 530). Richard Lakeman, a lecturer at Dublin City University, gives his own experience with epistemic injustice after feeling a profound effect from a prescribed psychotropic drug. "When I reported this to the prescriber, my claims were met with incredulity, as the reaction I experienced was quite unusual. As a professional, the veracity of my reporting of the symptoms or behaviour of others had never been called into question in the manner that it was when I was in the position of patient" (Lakeman, 2010, p. 151). Lakeman, a professional who does not have the added intersections of being a refugee or experiencing language barriers, faced an epistemic injustice when attempting to access mental health services. For refugees with mental disorders, such barriers may arise, for example, when going through the IME, or attempting to explain their symptoms to healthcare providers.

Another reasons people with mental disorders may be more likely to experience epistemic injustice is because of the widespread and deep-seated negative stereotypes and stigma surrounding mental disorders in our society (Crichton, Carel, & Kidd, 2017; LeBlanc-Omstead & Kinsella, 2016). One such stigma pertains to ignorance of societal norms, and lack of prosocial behaviour skills. This has been seen for example, in relation to autistic people, who are

perceived as being in opposition to these norms (Izuma, Matsumoto, Camerer, & Adolphs, 2011). A society's values and norms are deeply ingrained in the minds of those who live in it, and when something such as a mental disorder (which is very closely connected to how a person perceives values) disrupts a person's adherence to these constructs, it can be perceived as a threat to the society (Malla, Joober, & Garcia, 2015). Thus, non-adherence with societal values further contributes to negative stereotypes. One harmful stereotype that people with mental disorders face is that they are perceived as less truthful or cognitively reliable than neurotypical people or may be seen as being more prone to violent behaviour (Kurs & Grinshpoon, 2018a; Rueve & Welton, 2008; Sanati & Kyratsous, 2015). This is especially true for those living with mental disorders such as schizophrenia, personality disorders, and other psychotic disorders. There are also many perceived disadvantages of disclosing a disorder, including stigmatizing responses from family, such as 'get over it', minimising illness, or inadequate or inappropriate support (Griffiths et al., 2011). People with mental disorders can also be perceived as being more in control of their disorder than they actually are. A study regarding personality disorders showed that staff in hospitals were more likely to blame services users with personality disorders for their symptomatic behaviour because they believed that "service users with personality disorders have control and conscious knowledge of their behaviour - therefore, service users are responsible for their behaviour" (Pickard, 2011, p. 211). Thus, these stigmatizing beliefs and stereotypes, combined with the false belief that people with mental disorders are fully responsible for their symptomatic behaviours causes people to assign less credibility to people with mental disorders and contributes to epistemic injustice.

Another contributor to the higher prevalence of epistemic injustice faced by people with mental disorders is the value placed on 'hard' or objective evidence, as opposed to subjective reports of symptoms or experiences. Chrichton, Kidd and Carel note that in psychiatry there is basically no hard evidence such as X-rays or MRI scans available to show what a patient is feelings, and therefore the diagnosis needs to be made based on what a patient says and does. However, some psychiatrists feel that by approaching mental disorders from a biological perspective, they will be more accepted by other medical professionals (Crichton et al., 2017). While testimony is central to the provision of mental health services, "the self-reports (or introspections) of patients more often require corroboration or more 'objective verification'. Often when observations or self-reports are translated onto a scale, the number is ascribed greater significance than a person's testimony" (Lakeman, 2010, p. 151). This can lead to ignoring what a person is saying in favour of using biological tests to make diagnoses and treat people. Lakeman points out that dependence on biomedical explanations, or hard evidence, may also lead to hermeneutical injustices, as a reliance on hard evidence can lead to people forgoing "the opportunity to explore what historical, social, or environmental factors may actually have contributed to their 'depression'" (Lakeman, 2010, p. 152). In this way, society focuses too heavily on one solution (the biochemical one) and leaves behind all the others, resulting in a dearth of resources in those areas.

There may also be barriers to discussing the psychosocial aspects of mental disorder for neurodivergent refugees. Yael Peled notes language barriers are especially significant in the context of mental disorders, as the quality of care is highly dependant on the relationship between healthcare provider and patient (Y. Peled, 2018). In order to properly diagnose and

treat a mental disorder, there has to be an underlying relationship between the patient and practitioner. This could create issues in the context of the IME, as there is no existing relationship between the refugee and the physician - in fact, it is noted that even if a refugee has a family physician, they are not allowed to conduct the IME with them. Another issue arises in relation to translation, as "even when a translation supposedly exists, the assumption that the linguistic label corresponds to the exact same meaning is highly problematic" (Y. Peled, 2018, p. 362). For example, even if a refugee from Syria uses a word that directly translates to "depression", there may not be the same understanding in Arabic as in English for that word. Lack of understanding how mental disorders might vary between cultures, or how symptoms might be described differently in different languages, could contribute to experiences of hermeneutical injustice. As Peled says, "the existence of a language barrier may make patients who do not necessarily share a first language with a physician more vulnerable to epistemic injustice" (Y. Peled, 2018, p. 365).

The increased likelihood of people with mental disorders being exposed to epistemic injustice is increased due stigmatization, stereotyping, and language barriers. In light of this, epistemic injustice is a fitting theory to use to examine how refugees with mental disorders may experience injustice in the Canadian immigration system.

3.5: Applying Epistemic Injustice to this Project

This project focuses on how testimonial and hermeneutical injustices can arise in the immigration process for refugees with mental disorders, and how injustices could be minimized or prevented. In the next chapter I begin by reviewing policy and documents created by departments of the Canadian government describing the immigration process. I identify places where I believe testimonial or hermeneutical injustices may arise. This analysis focuses on two

parts of the immigration system, the Immigration Medical Examination and the interview processes that refugees and asylum seekers go through, as well as some policies regarding detention in the immigration process. In chapter 5, I consider how other features of a refugee's identity, such as gender, type of mental disorder, and age may impact experiences of epistemic injustices. I then discuss where other dimensions of epistemic injustice such as epistemic violence, epistemic privilege, epistemic oppression, epistemic exclusion, and epistemic justice could arise in the immigration system and introduce the concept of epistemic disenfranchisement. Finally, I provide suggestions on how epistemic injustices can be prevented in the immigration system, and how epistemic justice might be fostered.

3.5.1: Table 1 - Definition of Terms related to Epistemic Injustice

Term	Definition
Epistemic Injustice	Injustices committed against someone specifically in their capacity as a knower
Testimonial Injustice	When "prejudice on the hearer's part causes [them] to give the speaker less credibility than [they] otherwise would have given" (Fricker, 2007, p. 4)
Hermeneutical Injustice	When "a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker, 2007, p. 1)
Epistemic Justice	Requires both testimonial justice and hermeneutical justice.
Testimonial Justice	The correcting of one's own prejudices in credibility judgements reliably over time (Fricker, 2007)
Hermeneutical Justice	Occurs when a hearer reflects on what they find unintelligible because of a gap in hermeneutic resources, and adjusts or suspends judgement accordingly (Fricker, 2007)
Epistemic Violence	Epistemic violence is the "failure of an audience to communicatively reciprocate, ether intentionally or unintentionally, in linguistic exchanges owning to pernicious ignorance. Pernicious ignorance is a reliable ignorance, or a counterfactual incompetence that, in a given context, is harmful" (Dotson, 2011, p. 242)
Testimonial Quieting	Occurs when "an audience fails to accurately identify the speaker as a knower, thereby failing to communicatively reciprocate in a linguistic exchange due to pernicious ignorance in the form of false, negative stereotyping" (Dotson, 2011, p. 243)
Pernicious Ignorance	"A reliable ignorance, or a counterfactual incompetence that, in a given context, is harmful" (Dotson, 2011, p. 242)
Testimonial Smothering	Occurs "because the speaker perceives one's immediate audience as unwilling or unable to gain the appropriate uptake of proffered testimony… [they truncate] one's own testimony in order to insure that the testimony contains only content for which one's audience demonstrates testimonial competence" (Dotson, 2011, p. 244)
Epistemic Exclusion	An unwarranted infringement on the epistemic agency of knowers, or their ability to utilize shared epistemic resources effectively within a given community of knowers in order to participate in knowledge production or revision (Dotson 2014)
Epistemic Oppression	A "persistent and unwarranted infringement on the ability to utilize persuasively shared epistemic resources that hinder one's contributions to knowledge production" (Dotson, 2014, p. 116)
Epistemic Privilege	When a specific person or group's knowledge is seen as more valuable than another's.
Epistemic Humility	"An attitude of awareness of the limitations of one's own epistemic capacities, and an active disposition to seek sources outside one's self to help overcome these shortcomings" (Wardrope, 2015, p. 350)

Chapter 4: Analysis

Note: I have written this chapter to function as a standalone manuscript that I plan to submit to the Canadian Journal of Bioethics. The structure and content of the chapter is influenced by this decision, including the need to revisit and summarize some information found in earlier chapters of the thesis in order to situate the analysis that is presented.

4.1: Introduction

Each year, millions of people are displaced from their homes and in need of refuge. Many become internally displaced persons, who have been forced to flee from their homes but have not crossed a state boundary. In 2019, there were 45.7 million internally displaced persons (UNHCR, 2020). When displaced people do cross state borders, 73% initially travel to neighbouring countries. Turkey, for example, hosts the most refugees worldwide, 92% of whom are from the neighbouring country of Syria (UNHCR, 2020). While some refugees remain in the first country they enter after their displacement, others seek to continue their journey to countries like the United Kingdom, the United States, or Canada.

In Canada, there are two programs that allow refugees to enter the country. The first is the resettlement route. Resettlement is the transfer of refugees from a State where they have sought protection to a third State that has agreed to admit them as refugees and grant them permanent residency (PR) (UNHCR, 2018). Through this pathway, government assisted refugees and privately sponsored refugees can make their way to Canada after they have received a positive decision on their refugee application. In the past two years, Canada has been the top country in the world for refugee resettlement, having resettled 30,100 refugees of the 107,800 requesting resettlement in 2019 (UNHCR, 2020). The other pathway is the In-Country asylum

program, where asylum seekers apply for refuge and receive a decision regarding their refugee claim after they enter the country.

In Canada, like in many countries, this process is an arduous undertaking for anyone who goes through it. However, for refugees with a mental disorder, their experiences and knowledge may be viewed as less credible and they may struggle to communicate their experiences with others. As a result they may be subjected to epistemic injustices. This paper will examine where refugees with mental disorders might experience epistemic injustices in the Canadian immigration system and identify opportunities for how epistemic justices may be enhanced for refugees with mental disorders immigrating to Canada.

4.2: Epistemic Injustice

Epistemic Injustice is a theory most recently developed in Miranda Fricker's book *Epistemic Injustice: Power & the Ethics of Knowing.* It provides a valuable theoretical lens to examine the experiences of refugees with mental disorders, as it aims to make it possible to "trace some of the interdependencies of power, reason, and epistemic authority" and see how our conduct might become more epistemically just (Fricker, 2007, p. 4).

Epistemic injustice is broadly defined as a wrong committed against someone specifically in their capacity as a knower. The two main forms of epistemic injustice that Fricker identifies are testimonial injustice and hermeneutical injustice. Testimonial injustice occurs when "prejudice on the hearer's part causes [them] to give the speaker less credibility than [they] otherwise would have given" (Fricker, 2007, p. 4). The key attribute of a testimonial injustice is that the hearer must have a prejudice (that they may or may not be conscious of) which causes them to give the speaker less credibility than they would otherwise be given. Not all prejudices reduce a

speaker's credibility, for example, the model minority myth, which supports harmful positive stereotypes like 'all Asian people are good at math'. However, in cases of testimonial injustice the hearer's prejudice is a negative one which causes them to deflate a speaker's credibility which undermines or withholds proper respect for them (Fricker, 2007). The example Fricker offers of testimonial injustice is the police not believing a person specifically because they are Black.

The other form of epistemic injustice that Fricker discusses is hermeneutical injustice, which stems from more society-level deficits of shared tools of social interpretation. Hermeneutical injustice is when "a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker, 2007, p. 1). In other words, it is not a single person's prejudice that causes the injustice, but rather society's communal lack of understanding that does. One example that Fricker presents for hermeneutical injustices relates to post-partum depression. Post-partum depression was collectively ill-understood by society in the early 20th century, which left some women unable to explain their experiences after giving birth. Fricker quotes a part of Susan Brownmiller's memoir, where Wendy Sanford, who had been experiencing post-partum depression, attended a group meeting held by the women's liberation movement. Wendy describes hearing other women discuss their experience with post-partum and says "in that one forty-five-minute period I realized that what I'd been blaming myself for, and what my husband had blamed me for, wasn't my personal deficiency. It was a combination of physiological things and a real societal thing, isolation" (Fricker, 2007, p. 149). As a result of pooling their knowledge about their experiences, these women were able to identify that what they were experiencing after giving birth was not

their fault, but instead was a combined physiological and societal issue. They could now succinctly describe their experiences to others and no longer experienced hermeneutical injustice (Fricker, 2007).

The theory of epistemic injustice has continued to be developed since Fricker's work on it, leading to the articulation of concepts such as epistemic exclusion. Epistemic exclusion occurs when someone is barred from contributing their knowledge to the pooled resources regarding a topic (Dotson, 2014). For example, imagine that Immigration, Refugees and Citizenship Canada (IRCC) are conducting a review of the immigration system looking at whether enough supports are provided for disabled refugees. On the team conducting the review, there is a refugee with a physical disability, but no refugee with a mental disorder. In this theoretical situation, while physical disabilities are represented on the review team, mental disorders might not be. Because of this, there may be less understanding of the barriers that arise for refugees with mental disorder while immigrating and therefore less supports provided for them. Because the team failed to include a refugee with a mental disorder, this space has epistemically excluded refugees with mental disorders.

In each situation where the potential for epistemic injustice has been identified, acting in an epistemically virtuous way could instead promote epistemic justice. Fricker describes epistemic justice as the presence of both testimonial and hermeneutical justice (Fricker, 2007). This involves both reflexivity and awareness of one's own prejudices, as well as an openness to changing negative patterns that contribute to hermeneutical injustice (LeBlanc-Omstead & Kinsella, 2016). A similar concept is epistemic humility, which prompts people to recognize the limits of their epistemic capacities and learn from others as a way to overcome these

shortcomings (Wardrope, 2015). As each situation discussed in this paper holds the opportunity for both injustice and justice, suggestions will be made regarding how epistemic justice could have been promoted rather than injustice.

4.3: Mental Disorders in Refugee Populations

Depression, anxiety, and PTSD are among some mental disorders that have higher prevalence among refugee populations. A study comparing the health of refugees to other migrants in Canada showed that refugees experience a decline in health within two years of arrival and were more likely to report new emotional or mental health problems (Newbold, 2009). The authors posited that this could be because of traumatic experiences and the resettlement process that refugees go through (Newbold, 2009). Another study found that refugees and asylum seekers who experience trauma are more likely to have mental disorders as well as secondary psychotic features, which are defined in the Diagnostics and Statistics Manual 5th edition (DSM-V) as psychotic disorders due to another medical condition which include hallucinations or delusions (APA, 2013; Hameed et al., 2018). In the Canadian context it was shown that rates of psychotic disorders, a subset of mental disorders, were higher in refugees from East Africa and South Asia (95% and 51% increased risk respectively) than in the general Canadian population and non-refugee migrants (Kirkbride & Hollander, 2015). The researchers themselves point out that this is an emerging field of research that requires more investigation. Thus, more attention should be paid to how refugees with mental disorders experience their immigration, with the goal of mitigating or removing any situations which result in experiences of injustice.

There is a dearth of research regarding ways that refugees with mental disorders might experience epistemic injustice. However, there have been several studies which discuss how people with mental disorders in general are more likely to experience an epistemic injustice (Carel & Kidd, 2014; Crichton et al., 2017; Kurs & Grinshpoon, 2018a; Lakeman, 2010). As noted by Carel and Kidd, people with mental disorders are made more vulnerable to epistemic injustices "through the presumptive attribution of characteristics of unreliability and emotional instability that downgrade the credibility of their testimonies" (Carel & Kidd, 2014). The chance of negative stereotypes is even more prevalent with mental disorders than with other forms of disability (Crichton et al., 2017). The increased stigmatization of mental disorders can distort a person's perception of someone with a mental disorder, making them more at risk of experiencing epistemic injustices. Another factor that influences whether a refugee with a mental disorder might experience epistemic injustice is regarding language barriers. Yael Peled notes that the significance of language barriers becomes even greater in the context of mental disorders, as "psychiatric practice is still highly dependent on the quality of clinical relationships" (Y. Peled, 2018). This can pose a significant barrier in the context of the immigration medical exam (IME), where there is no pre-existing relationship between practitioner and patient, and as a result no pre-existing trust.

This paper will focus on three forms of epistemic injustice that refugees with mental disorders may experience in the immigration process, testimonial injustice, hermeneutical injustice, and epistemic exclusion. Suggestions will be offered as to how these injustices can be avoided, with the goal of decreasing experiences of injustice for future refugees and asylum seekers with mental disorders and instead promoting epistemic justice.

4.4: Overview of the Canadian Immigration System

In order to identify where epistemic injustices occur for refugees with mental disorders, it is important to have a basic understanding of the immigration process. When entering the Canadian refugee program, people from outside of Canada must apply to the Refugee and Humanitarian Resettlement Program (Canada, 2019g). They must be identified and referred by either the UNHCR, a private sponsor, or a community group sponsor. Once identified, their cases are processed and they can apply for refuge in Canada. Applicants are assessed on whether they fit the definition of either a Convention Refugee Abroad Class or Country of Asylum Class (Canada, 2019b). When accepted by the referral organization, they undergo a screening process to ensure that "there are no issues related to security, criminality, or health" if they were to become refugees in Canada (Canada, 2020c). The 'principal applicant' (the individual or head of the family) must fill out IMM 0008 Schedule 2 forms for themselves and any family members. The applicants are then interviewed by a migration officer who assesses the validity of their claim for protection. For asylum seekers, who apply for refugee within Canada, they must undergo an quasi-judicial interview with a member of the Immigration and Refugee Board (IRB). Present at this interview is a member of the IRB, the refugee(s), along with their counsel if they have one and potentially a representative of the CBSA or IRCC (Canada, 2021a). After this interview, the IRB member makes a ruling on whether or not the individual or family may immigrate to Canada as refugees. In addition to background checks and detailed disclosure of their situations, an IME is required of convention refugees and asylum seekers. The IME must be conducted by a panel physician approved by the Canadian government in order to evaluate a person's perceived risk to public health and safety (Canada, 2019d; Canada, 2019e).

Asylum seekers who cross borders illegally, those who are going through the immigration process, or those who have been flagged by the authorities as people who pose a threat to the country or who will be refused protection may be placed in Immigration Holding Centers (von Werthern et al., 2018). The use of refugee detention has been critiqued by various organizations, with the UNHCR calling for a cessation of detainment or use of alternatives (International Detention Coalition [IDC], 2016; UNHCR, 2012). Detention is a harmful policy used to control immigration, and is detrimental to both physical and mental health as detention centers are common sites for human rights abuses (Zimmerman, Kiss, & Hossain, 2011). In reality, detention is most commonly used if a person is deemed 'unlikely to appear', with 93% of asylum seekers being detained on the grounds of identity or flight risk, and no allegations of being a danger to the public or a security risk (CCR, 2016b). The second most likely cause was people being judged to be dangerous and unlikely to appear with just 340 detainees (CCR, 2016a). While the average duration of a person's detention is around one month, even this amount of detainment can have harmful effects (CCR, 2016b; Nair, 2019). Cleveland et al. found that after a median of 18 days of detainment, asylum seekers were almost twice as likely to experience clinical levels of PTSD symptoms, and 50% more likely to have clinical levels of depression (Cleveland et al., 2018).

4.5: Testimonial Injustice

One step in the immigration process where refugees with mental disorders may be susceptible to testimonial injustice is during the IME. The IME is very thorough, as refugees must be checked for communicable diseases, their physical and mental fitness must be assessed, etc. For refugees with mental disorders, specifically PTSD, going through the IME may be particularly traumatic. To illustrate how this situation might come about, I will describe a

hypothetical scenario involving a male asylum seeker with PTSD resulting from a sexual assault he experienced while in a refugee camp. A specific trigger for him, or a stimuli that symbolizes or resembles an aspect of the traumatic event which causes intense or prolonged distress, is anyone touching his lower body (APA, 2013). Because of the shame and stigma he feels surrounding his assault, he has not disclosed his experience of sexual assault to anyone, instead saying that he was tortured. In the IME, the physician begins the examination with his upper body. As the physician begins to examine his lower body, the asylum seeker is suddenly triggered, and asks the physician to stop. He discloses for the first time that he experienced sexual assault, however, the physician does not believe him. Their disbelief is a result of two prejudices, the first being a belief that that men do not experience sexual assault, and the second being that if the physical examination might result in triggering these past experiences for him then he would have mentioned it at the outset. The fact that the asylum seeker previously reported that the had been tortured contributes to the physician's doubt of SA having occurred. As a result of these factors and assumptions, the physician has the perception that the asylum seeker is likely lying or hiding something. The physician hurries through the rest of the exam so as to minimize the asylum seeker's discomfort but also makes a note in the man's file that he refused to be fully examined. Later, this note in the asylum seeker's file results in him being detained upon arrival in Canada and questioned by the CBSA.

In this example, the asylum seeker suffers a testimonial injustice because of a lack of understanding for his mental disorder. His testimony regarding his sexual assault was seen as invalid by the physician because of their belief that men do not experience sexual assault. When the asylum seeker mentions that he is triggered halfway through the exam, the physician does

not immediately believe him, but instead becomes suspicious. Because they assign less credibility to the refugee's testimony and describe the situation in the man's record as a refusal to cooperate, the physician also causes more harm for the refugee further into the immigration process as he is placed in detained upon arrival in Canada. Because of the physician's belief that men cannot experience sexual assault, they dismiss the refugee's testimony. This is one theoretical situation in which refugees with mental disorders could experience testimonial injustice. If the physician had reflected upon their assumptions regarding who can or cannot experience sexual assault, and confronted their bias, they could have approached this IME with an attitude that promoted testimonial justice. Instead, their prejudice created a situation of testimonial injustice.

Another step in the immigration process where refugees with mental disorders might experience testimonial injustice is during the interview process. In this interview, whether the IRB member or migration officer is knowledgeable regarding mental disorders can greatly impact the outcome of the interview. Certain behaviours may act as physical symptoms for people with mental disorders. For example fidgeting, nervous tics, downturned eyes, or stuttering are just a few that may be seen in a high stress situation such as in an interview. However, because of negative associations with these behaviours, namely that people do them when they are lying or trying to hide something, they can lead people to falsely believe that a speaker is lying or deceiving them. Similarly, if a refugee's mental disorder causes memory consolidation issues, this could cause the person presiding over the interview to view them as less credible. Depression, for example, can cause memory blackout around traumatic events, and mood disorders have been shown to have an effect on memory consolidation and recall (APA, 2013; Herlihy, Scragg, &

Turner, 2002; Marvel & Paradiso, 2004; Williams & Dritschel, 1988). While an inability to remember details of events is itself not indicative of mental disorders, it is an issue that could arise with more frequency for refugees with mental disorders. When recounting the events of their immigration and discussing triggering events, a refugee with depression might not be able to present the facts as accurately in person as they did in the written form. Any small deviations from the written form, or decrease in the number of details provided, may make the interviewer suspicious of their testimony, and could lead to the refugee being treated with less credibility (Cleveland et al., 2014; Rehaag, 2017; Rousseau, Crepeau, Foxen, & Houle, 2002; Sternglanz, Morris, Morrow, & Braverman, 2019). Without a solid understanding of how certain mental disorders can affect memory, IRB members or migration officers may give refugees with these disorders less credibility than they deserve. Conversely, if the refugee is undiagnosed or misdiagnosed, their inability to remember might not be understood as a symptom of a mental disorder, and instead the person interviewing them might attribute forgetting an event to a refugee forgetting their lie.

There is also a third scenario, in which IRB members or migration officer are made aware of mental disorders and choose to ignore their impact. For example, one IRB member, David McBean, did not admit a single refugee claimant from the 174 decisions he made over a three year period (2008-2010) (Rehaag, 2017). In cases where counsel asked for him to take into account mental disorders, he would dismiss these arguments because “no expert psychological evidence was presented about impairing psychological conditions” (Rehaag, 2017, p. 51). In other cases, “he disregarded expert psychological reports because he believed that the claimant duped the medical professional” (Rehaag, 2017, p. 52). Thus, even when the fact that an asylum

seeker has a mental disorder is brought to the attention of the IRB member, it is not guaranteed that the member will modify their treatment of the claimant and take into account how their mental disorder could impact their testimony. In order for testimonial and epistemic justice to prevail in scenarios such as these, an understanding and acknowledgement of the symptoms of mental disorders as well as a sensitivity to how they might present is required of IRB members or migration officer.

Cleveland, Rousseau, and Guzder's paper *Cultural Consultation for Refugees,* provides a case study in which this form of prejudice is clearly present (Cleveland et al., 2014). They give a case vignette of Begum, a 30-year-old Bangladeshi Muslim mother who fled from her country after domestic violence, and experienced sexual assault both in her marriage and from the agents who transported her to Canada. She applied for refugee status in Canada, but she was too ashamed to recount the rapes she had experienced. During her trial she dissociated while attempting to recount the traumatic events she had experienced[7]. As a result of her dissociation, the refugee board rejected her claim due to differences between her testimony and her written application form. Because her claim was rejected, Begum then had to go through an appeal process that lasted six years, during which time both Begum and her children experienced worsening depression and anxiety (Cleveland et al., 2014).

In this case vignette there is a clear example of testimonial injustice. Because Begum was unable to recount the traumatic events that she had experienced while immigrating, the

[7] Dissociative reactions can include flashbacks in which the individual feels or acts as if the traumatic event(s) were recurring at various levels of severity. The most severe symptoms include a complete loss of awareness of present surroundings, dissociative amnesia resulting in an inability to remember aspects of traumatic events, depersonalization meaning a detachment from oneself, or derealization, which is an experience of unreality of surroundings (APA, 2013).

testimony that she gave in the IRB hearing was not consistent with what she had written in her application form. As a result, the IRB member did not believe her testimony. While Begum was eventually granted refugee status, this initial injustice led to further traumatization as Begum and her children waited 6 years to be granted status. In this case, the testimonial injustice was a result of the lack of understanding of the symptoms of mental disorders, such as how refugees with these disorders may be unable to answer questions or may not present information in the same way as on their application form. If the IRB member had approached Begum's case with a better understanding of the symptoms of PTSD, as well as an open mind about how recounting such traumatic events could impact Begum's ability to testify, they could have promoted testimonial justice. However, this was not the case, and Begum was unfortunately subjected to an epistemic injustice.

Finally, some policies pertaining to detention may also increase the likelihood of refugees with mental disorders experiencing testimonial injustices. The IRPA outlines reasons for the detention of refugees, permanent residents or foreign nationals, who are people without Canadian citizenship. These include if there are reasonable grounds to believe that a person will not appear for immigration proceedings, if they are a danger to the public, or if they are uncooperative in establishing their identity or their identity is unknown (Canada, 2001). However, the operating manual for detention also lists other factors to consider under section 6.4, including "history of violent or threatening behaviour demonstrated by the person" and "suspected or known untreated addictions or mental illness linked to a violent behaviour" (Canada, 2020a, p. 18). Furthermore, in a paragraph titled 'Mental Health' also in section 6.4, it states that "instability of the person associated with mental imbalance at the time of the

interview may be an important indicator in the assessment of the danger, and may point to future violent behaviour" (Canada, 2020a, p. 18). These policies rely on stereotypes of mental disorders, and as a result creates opportunities for testimonial injustices to be inflicted on refugees with mental disorder.

For example, Uday is a male refugee with schizophrenia and who experiences seizures, who arrived in Canada in 2011 (Gros & van Groll, 2015). Upon his arrival to Canada, he was stopped by airport officials and brought into a holding room where he was questioned without an interpreter present (Gros & van Groll, 2015). He was detained before being able to get his luggage which contained his medication, and despite asking for his medication repeatedly, the CBSA officials refused his requests, and insisted that he finish the interview (Gros & van Groll, 2015). Because of the lengthy flight, and lack of access to food, water, or medication, Uday became increasingly agitated, until he "freaked out"(Gros & van Groll, 2015, p. 61). These actions presumably impacted the CBSA's decision to detain Uday, as he had a further outburst in his interview for asylum protection where "he became frustrated and slammed a phone, knocked over a computer, and was restrained" (Gros & van Groll, 2015, p. 61). Uday recalls that "I broke the phone and computer and then [they] put me in jail", thus suggesting that these 'violent outbursts' impacted the decision to detain him (Gros & van Groll, 2015, p. 61). At no point are Uday's outbursts described as being harmful or directed at people. Rather, they can be seen as physical manifestations of Uday's frustration with the system, manifestations that he was less in control of because he was denied his medication. It wasn't until he was detained in the Metro West Detention Center that Uday was able to continue taking medication, weeks after his arrival and initial detainment by the CBSA (Gros & van Groll, 2015). Uday's requests for his

medication were denied multiple times, and the subsequent expression of his frustration lead the CBSA to believe the has was violent and a threat. This illustrates how the lack of understanding and accommodation of mental disorders, as well as the stereotyping of mental disorders, and the conflation of expressions of frustration with violent and dangerous behaviour can negatively affect the immigration of refugees with mental disorders.

However, Uday's story does not end there. Uday remained detained for three years, and he relayed feeling like "the fact that I have schizophrenia made it more difficult for me to get out of detention" (Gros & van Groll, Gros, 2015, p. 62). The CBSA claimed that Uday was willfully misleading and attempting to impede their investigation into his identity, because he provided background information about himself to the CBSA that turned out to be false or unverifiable (Gros & van Groll, 2015). In Uday's story, a refusal to allow him his medication lead to his symptoms of schizophrenia to become more pronounced, and as a result he was detained. There were also points where Uday did not take his medication because it made him "feel like a zombie", but when it became clear that this was impeding his release, Uday began taking his medication more regularly (Gros & van Groll, 2015, p. 62). CBSA officials believed that the testimony he provided was purposefully false, and his lawyer indicated that "a proper appreciated of his particular illness would not included the unreasonable expectation that he provide reliable and consistent historical information (Gros & van Groll, 2015, p. 62). Because Uday had a mental disorder, his testimony was viewed as being inherently untrustworthy, and not as a symptom of his schizophrenia. This testimonial injustice impacted Uday's ability to be free of detention.

These policies pertaining to detention add to "the stigma and stereotyping of persons with a mental illness and make detention more likely and release more difficult" and further increase the possibility of testimonial injustices occurring (Peoples, 2007, p. 11). By promoting the detainment of people who have mental disorders that are considered 'dangerous' to the public, this causes immigration officers to rely on stereotypes of mental disorders that are present in today's society. This also leads to the detention of refugees with mental disorders, which has been shown to have an extremely negative effect on the health of refugees (J. Cleveland & Rousseau, 2013). These policies make it more likely that a person's testimony will not be regarded as credible because of stereotypes and prejudices, thus working against the promotion of epistemic justice. While epistemic and testimonial justice call for open-mindedness and withholding judgement based on prejudices such as those promoted by stereotypes and stigma, these policies make it more likely that refugees with mental disorders will experience epistemic injustices.

4.6: Hermeneutical Injustice

The next form of epistemic injustice that will be discussed is hermeneutical injustice. One area in which a refugee with a mental disorder might be particularly vulnerable to a hermeneutical injustice is during the IME, because hermeneutical resources (also known as interpretive resources) are lacking for both the refugee and the physician. An example of this would be if a male refugee with PTSD as a result of sexual assault is trying to explain his experiences and symptoms to an IME physician. In many cases, men lack the ability to describe their experiences with sexual assault. Instead of being classified as rape or sexual violence, their experiences may be classified as 'abuse' or 'torture', which could both reinforce and be a result

of the view that men cannot experience sexual violence (Sivakumaran, 2007). Additionally, the English language has been described as lacking the terms necessary to describe male sexual assault (McMullen, 1990; Sivakumaran, 2007). So on the survivor's side, there is a lack of resources to adequately explain what they have experienced. Hermeneutical resources are also lacking on the side of the person that they are disclosing to. Doctors in the Panzi Hospital in Eastern Democratic Republic of the Congo have reported that they do not know how to treat men who have experienced sexual assault, and other studies have reported that many healthcare officials found it so difficult to discuss this topic that they would either skim over it or ignore it all together (Wedi, 2018). In the context of immigration, this aversion to discussing how men can be assaulted could affect how male refugees are treated. Because of the aversion to discussing male sexual assault by physicians and patients alike, even the language that men can use to say they have been assaulted has been neglected and underdeveloped (Wedi, 2018). As a result, there are fewer hermeneutic resources available for men when trying to express their experiences of sexual assault. In the IME, this could lead to a male refugee being ill equipped to explain why he is unwilling to undergo a physical examination. As a result, he might be deemed inadmissible to immigrate to Canada.

It has also been shown that some mental disorders may be culturally specific, while others may be described differently based on a person's cultural background (Gopalkrishnan, 2018; Henderson, Nguyen, Wills, & Fricchione, 2010; Kirmayer, Dao & Smith, 1998; Office of the Surgeon General, Center for Mental Health Services, & National Institute of Mental Health, 2001). Researchers such as Yael Peled have noted how language barriers can contribute to epistemic injustices (Y. Peled, 2018). In the case of these disorders, when a refugee describes

these experiences to the IME physician, neither person may have the proper hermeneutic resources to communicate effectively with the other. For example, for Laotian people who are experiencing depression, they may describe feeling 'tense' as feeling 'like a balloon blown up until it is about to burst' (Henderson et al., 2010). This difference between how depression is described in Laos and in Western psychiatry was shown to contribute to a general inability of Western psychiatrists to recognize the Laotian symptoms of depression (Westermeyer & Zimmerman, 1981). Because of how refugees from difference cultures may describe their symptoms, physicians who are only knowledgeable about English descriptions of mental disorders might not be able to properly diagnose people from other cultures. As a result, if the refugee experiences difficulties later in the immigration process, such as in an interview setting, they won't be able to explain that their behaviour, for example not remembering an event, are a result of depression. The opposite may also be true, with Western psychiatrists over diagnosing mental disorders in refugees because they fail to take into account cultural difference. Schizophrenia, for example, has been shown to present differently based on a person's cultural background. While Americans with schizophrenia hear more critical and hateful voices, people from Asian or African backgrounds recognize the voices as benign and positive, sometimes interpreted as ancestors or as God (Luhrmann, Padmavati, Tharoor, & Osei, 2015). Hearing voices may also be recognized as a culturally acceptable experience in other societies (Henderson et al., 2010). If a physician is not sensitive to these difference, they may be tempted to disregard their patient's positive experiences and instead pathologize their behaviour because of their belief that hearing voices can only be a detrimental symptom of a mental disorder.

In these cases, acting in an epistemically just way would require listeners to recognize their prejudices, and instead of acting on them, withhold judgement until they have a more complete understanding of the situation. In the first example, the physician should approach each disclosure of sexual assault as truthful, regardless of the gender of the patient. Similarly, if someone uses phrases to describe their experiences which are unfamiliar to physicians, they should not dismiss them, but instead try to work through the patient's experiences to get a more comprehensive understanding of their symptoms.

One way in which this lack of shared hermeneutical resources between cultures could be addressed is through increased training in cultural competency or cultural sensitivity. Cultural competency is defined as "the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patient's social, cultural and linguistic needs" and aims to make healthcare more accessible to people from diverse ethnocultural backgrounds (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Laurence J. Kirmayer, 2012, p. 151). Cultural sensitivity is a more broad term, which calls for "having an awareness of the importance of cultural factors; being aware of how cultural factors might impact the therapeutic relationship; and having an awareness of one's own personal biases and one's own culture" (Benuto, Singer, Gonzalez, Casas, & Ruork, 2021, p. 160). However, the concepts of both cultural competence and sensitivity have been critiqued. For example, commentators have pointed to cultural competency's tendency to reify and essentialize cultures into a specific set of characteristics, while cultural sensitivity has been described as poorly defined (Benuto et al, 2021; Kirmayer, 2012). In light of these critiques, other researchers have suggested concepts such as cultural safety or cultural humility. Cultural safety was introduced in nursing by Papps

and Ramsden in 1996, and defined as "the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognises the impact of the nurses' culture on own nursing practice" (Papps & Ramsden, 1996, p. 491). It was introduced in New Zealand in response to the Maori people's (the Indigenous peoples of New Zealand) inequitable health status and relationship with medical care, as well as inadequate and insensitive treatment of Maori patients. The National Aboriginal Health Organization in Canada has since advocated for cultural safety as a paradigm to guide healthcare for Indigenous patients (Kirmayer, 2012). Cultural humility, on the other hand, "incorporates a life-long commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partner-ships with communities on behalf of individuals and defines populations" (Tervalon & Murray-García, 1998, p. 117). The concept of cultural humility would be especially useful in the immigration process, as training immigration officers, IME physicians or IRB members on how power dynamics can arise between refugees and officials, and how they can be minimized, could help to break down these power differentials. By creating new hermeneutic resources for professionals in the immigration system through the practice of cultural humility, this could help reduce the likelihood of hermeneutical injustices and promote epistemic justice through more mutually beneficial partnerships within the immigration system for refugees with mental disorders and professionals.

4.7: Epistemic Exclusion

The final form of epistemic injustice that I will discuss is epistemic exclusion. Epistemic exclusion is an unwarranted infringement on a person's ability to successfully utilize shared

epistemic resources within a given community of knowers in order to participate in knowledge production and revision (Dotson, 2014). As with the previous forms of epistemic injustice discussed, epistemic exclusion is closely tied to power structures in society. While some may argue that this form of epistemic injustice is a by-product of social and political oppression, there are situations in which the epistemic resources that are available and the system within which those resources exist might be "wholly inadequate to the task of addressing the persisting epistemic exclusions" (Dotson, 2014, p. 116).

In the context of this research, it is clear that refugees with mental disorders experience epistemic exclusion in the creation and maintenance of the immigration system's policy. Despite having firsthand experience of navigating Canada's immigration system, and as a result having valuable knowledge concerning where refugees could experience injustice, there is no mention of refugees with mental disorders who have successfully immigrated to Canada being included in reviews of immigration policy. The Canadian government does conduct consultations with Canadians. However, only 11 of the 797 consultations listed are related to immigration (Canada, 2021b). From the descriptions available online, it does not appear that any of these consultations looked at how immigration is experienced by refugees. Nor do they mention the inclusion of refugees specifically in their consultations or a focus on how mental disorders could impact a refugee's immigration (Canada, 2021b). As a result, immigration policy appears to lack the perspective of refugees who have resettled in Canada and could provide an 'insider' perspective of the various barriers refugees with mental disorders may face when immigrating.

A more specific example of the exclusion of refugees with mental disorders from contributing to epistemic spaces is the 2018 external audit of detention practices in Canada.

Despite closely following the detention and appeal process of 18 individuals between 2010 and 2017, the auditors never directly interacted with the refugees who they were observing, nor did they discuss detention practices with any refugees who had previously been detained (IRB, 2018c). This audit never consulted the refugees themselves on the outcome of the audit, nor were they consulted during the interpretation of their experiences. This clearly epistemically excluded refugees from the interpretation of their own lived experiences. It is only through the direct inclusion of refugees and refugees with mental disorders that they can effectively share their experiences. Increased inclusion of the refugee population in future reviews is one way that epistemic justice could be promoted.

4.8: How can these injustices be addressed?

In order to decrease the possibility of refugees with mental disorders experiencing epistemic injustices during their immigration process changes must be made on multiples levels (see table 2 for a summary of recommendations). One strategy to address epistemic injustice in the immigration system is to educate people on how to practice epistemic justice. Hermeneutical justice could be promoted through increased education on cultural humility and mental disorders. The people involved in the immigration system may lack hermeneutic resources to navigate situations involving mental disorders. As seen in the examples presented, those in power might not recognize how mental disorders present, or they may have insufficient resources available to discuss them. On the other hand, refugees with mental disorders may not be able to articulate or express how having a mental disorder can impact the treatment that they receive while immigrating. Increasing the availability of hermeneutical resources for everyone involved in the immigration process would help promote hermeneutical justice.

Implementing a more person-centered approach to immigration could be a more structural-level approach to addressing epistemic injustices. Many policies that were identified in this research focused more on completing each step of the immigration process than supporting the refugees who are immigrating to Canada. Despite the creation of guidelines for the IRB in recent years pertaining to how vulnerable groups should be treated during interviews, there were very few concrete examples of accommodations available for refugees with mental disorders. By conducting interviews with refugees with mental disorders it could be determined whether there are discrepancies between what the guidelines suggest and what is implemented. This could also help to shift the immigration process to be more person-centered. Instead of rejecting a refugee's claim because they were unable to remember specific events, an IRB member could instead suggest that the interview be postponed until the refugee is more prepared for the interview and could ask if they are in need of accommodations. By increasing education and changing the culture of the immigration system from one that is focused on getting people to move through a checklist, to one that focuses on the people themselves, the immigration system can start to address the structural issues that allow for epistemic injustices to take place.

More specific changes can be suggested in order to prevent testimonial injustices, and instead promote testimonial justice. In the IME, testimonial injustice could be prevented by creating more lenient policy and allowing refugees with mental disorders to have their IME conducted by a known physician instead of only specific panel physicians. Knowing the person who is conducting the IME may make going through the exam an easier process for refugees with mental disorders, and also decreases the risk of them experiencing a testimonial injustice.

As they already have an existing relationship with that physician, there is a baseline level of familiarity and potentially some trust existing in the relationship. For example, if a refugee camp has a medical clinic, or has a doctor who routinely visits the camp, this person would be known to the refugee community and might be more trusted than an unknown panel physician. Additionally, a known physician will be familiar with the refugee's history and will be able to better understand how previous experiences might make them hesitant to go through certain aspects of the IME. If a patient cites PTSD or anxiety as a reason for why they are uncomfortable or unable to finish the IME, they are more likely to be listened to and believed by a physician they know. If they are unable to complete the exam, then refugees should not risk an automatic rejection of their application. Instead, they should be able to provide a reason for why they couldn't go through with that aspect of the exam and should not be penalized for this. As it currently stands, the guide to IMEs for panel physicians notes that physicians should "accommodate personal and cultural sensitivities, while keeping in mind that IME standards must be respected"(IRCC, 2020). This suggests that while some accommodations are available, it is important that the structure of the IME not be disrupted significantly. Efforts are needed so that refugees do not experience additional trauma as a result of the immigration process, and so that more accommodations are in place to account for people who have experienced trauma not being able to complete the medical examination.

More concrete accommodations should also be available to refugees during the interview process. For the interview, when an asylum seeker makes their case for why they should be allowed into Canada as a refugee and the Refugee Protection Division (RPD) makes a decision on their claim, there is no mention of available accommodations. Additionally, if an

asylum seeker is unable to attend their set hearing dates, there are very strict guidelines for how to postpone it, including requiring a medical certificate or a detailed explanation of how their medical condition prevents them from attending the hearing (IRCC, 2018a). The objective of this interview is to assess the asylum seeker's claim for refuge in Canada, but these guidelines make it more difficult for asylum seekers to tell their story and make their case for refuge. One way that refugees with mental disorders could be accommodated could be changing the format of the interview. For example, in hearings conducted by the Refugee Appeal Division during the appeal process the refugee is not required to give an oral testimony (Canada, 2020b). Instead, the decision is based on the written evidence already submitted. This format could be adapted to fit the interviews with the IRB or migration officers, so that it is less about testing how well the refugee remembers what they wrote on their forms, and instead is about interviewing and assessing the refugee as a whole. Another accommodation could be making the process of postponing interviews easier. The goal of the interview process is to fairly assess a refugee's claim but making the process to postpone an interview difficult means that some asylum seekers with mental disorders may not be able to present their story how they would like to or may not be able to be present for the interview at all. This does not ensure that refugees have a fair interview and could result in some people being rejected because of lack of accommodation for mental disorders. These suggestions would not only benefit refugees with mental disorders but could also increase the overall accessibility of interviews to refugees who are immigrating to Canada.

As mentioned above, more training should be provided to the physicians, migration officers and IRB members who are involved in the immigration process. This training would be

particularly useful for preventing testimonial injustice in the IME or immigration interviews. While the physicians who complete the IME will already be trained on mental disorders and their symptoms, more education on how culture may affect symptom presentation could prevent situations where testimonial injustice could occur. Additionally, promoting more patient-centered care practices in the IME could increase understanding and compassion for what refugees with mental disorders are going through, and could help increase their level of comfort during the IME. For interviewers, ensuring at the very least a basic understanding of symptoms of common mental disorders such as PTSD, depression or anxiety could improve refugee's experience of the IRB interview. This way, if a refugee with PTSD dissociates during the interview, or a refugee with depression cannot remember a specific event, the interviewer will be better placed to assess the situation and its implications for the refugee's credibility. Increased training and understanding of mental disorders would support refugees who do not have a diagnosis, as well as those who do. By being more aware of mental disorders, even if a diagnosis is not noted in a refugee's file, an IRB member or migration officer may be able to recognize certain behaviours as potential symptoms of mental disorders instead of automatically interpreting them to be indicators of deception. In general, increased training for professionals in the immigration process could help prevent testimonial injustices.

A crucial change that would remove situations in which testimonial injustice can occur is updating policies that promote reliance on stereotyping and prejudice, such as the detention policy section titled 'Mental Health' which suggests detaining people who have or are suspected to have a mental disorder linked to violence. This policy perpetuates the false stereotype that specific kinds of mental disorders make people more dangerous and prone to violence, even

though there is no significant evidence supporting this claim (Varshney, Mahapatra, Krishnan, Gupta, & Deb, 2016). Relying on this kind of reasoning when deciding who should be detained upon entering Canada creates a system where refugees with mental disorders are punished because of their disorders, and further harms a vulnerable group. Because of these policies which promote a dependence on stereotypes of mental disorders, refugees with schizophrenia or psychotic disorders are more likely to experience testimonial injustice. Removing this policy is an essential step towards improving the immigration system and ensuring refugees with mental disorders do not experience testimonial injustices.

Finally, more refugees with mental disorders should be included in the creation of immigration policy to address the epistemic exclusion they experience in this area. Refugees with mental disorders who have gone through this process would be able to point out flaws in the system that could otherwise go unnoticed by policy makers. In addition to identifying shortfalls of the system, they would also be able to explain what facilitated their immigration to Canada, which would allow the immigration system to build on what is working already. Treating refugees with mental disorders as knowledge holders could improve the immigration process drastically and is an important step towards affording them the epistemic respect that they deserve. A next step for research in this area would be to conduct interviews with refugees with mental disorders, so that their experiences can be documented, and more concrete examples of epistemic injustice can be identified in the immigration system.

4.8.1: Table 2 - Summary of Recommendations

Form of Epistemic Injustice	Suggestions for Addressing Them:
Testimonial Injustice	- Allow known physicians to conduct the IME for refugees with mental disorders - Increase training for IME physicians and IRB members - Revise guidelines or policies to address stereotyping of mental disorders
Hermeneutical Injustice	- Increase training regarding cultural differences - Revise policy to be a more person-centered approach to Immigration
Epistemic Exclusion	- Include refugees (including refugees with mental disorders) in creating or revising future immigration policy - Conduct focus groups with refugees with mental disorders to better understand how they experience the immigration process under the current policies

4.9: Conclusion

There are a range of situations in which refugees with mental disorders could be subjected to epistemic injustices. In order to begin addressing these injustices, policies that could contribute to these injustices should be revised, refugees with mental disorders should be included as stakeholders in reviewing the immigration process, and the training that immigration officials and IME physicians receive should include issues related to epistemic justice. As a leader in the resettlement of refugees, Canada should ensure the respectful treatment of refugees and asylum seekers. Taking to heart the recommendations listed in this paper is a step towards promoting epistemic justice and equity for refugees with mental disorders.

Chapter 5: Discussion

This chapter builds on the analysis presented in the previous chapter which identified where opportunities for epistemic injustice could arise in the immigration process for refugees and asylum seekers with mental disorders. l begin by introducing the concept of intersectionality, and how a refugee's gender, age, type of mental disorder may impact their experience with epistemic injustice. The following section will look at how designated representatives and the related policies may expose refugees with mental disorders to epistemic injustice. I then introduce the concept of epistemic disenfranchisement, which describes the cyclical and compounding nature of epistemic injustices. After identifying where injustices may occur, I identify where epistemic justice may arise in the immigration process, and how it can be promoted. Finally, I reflect on this project, and provide suggestions for future research.

5.1: Intersectionality

As discussed in the previous chapter, neurodiverse refugees are more vulnerable to experiencing epistemic injustices than neurotypical refugees. The concept of intersectionality can help to explain why this is the case. Meant to explain how various aspects of our identities interact with and influence our experiences, intersectionality recognizes how single axis thinking undermines struggles for social justice and equity (Cho, Crenshaw, & McCall, 2013). The population that this project focuses on, refugees with mental disorders, already exist on two axes - citizen or non-citizen and neurotypical or neurodivergent. The intersection of these two axes compound to make these individuals increasingly vulnerable to experiences of epistemic injustice.

5.1.1: Gender & Sexuality

An important aspect of a person's identity that impacts their experience while immigrating is their gender. Whether a person identifies as a woman, a man, or is transgender or nonbinary can impact how they are perceived and how they are treated. Although rates of depression have been shown to be higher in women than in men, there is not a consensus among those who study mental disorder in refugee populations whether gender is statistically significant (Abate, 2013; Albert, 2015; Georgiadou et al., 2017). However, male refugees with mental disorders may face different prejudices when they are attempting to immigrate to Canada. One issue that male refugees may face is the invalidation of their trauma, specifically in regard to sexual violence. Although sexual violence and rape have been recognized as a weapon of war and a crime against humanity, it is primarily seen as a crime that is committed against women and girls (Wedi, 2018). This is obviously not the case, as people of all genders can experience sexual violence. In fact, reports have indicated that refugees are particularly vulnerable to sexual violence committed by men against men in conflict regions, and although it is not committed at the rate of sexual violence committed against women, it is still incredibly widespread (Sivakumaran, 2007). The reasons as to why men are seen as less susceptible to sexual violence could lie in stereotypes of masculinity, and the combination of shame, guilt, confusion, and stigma that results from the disclosure of sexual violence (Sivakumaran, 2007). These same stereotypes and stigmas could prevent an IRB member from believing a male refugee's claim about trauma and PTSD in the IRB hearing. For example, if a man claims that he is unable to return to his country because he was raped there and has since developed severe PTSD, the incorrect belief that a man cannot be raped could prevent the IRB member from believing his story. This could cause them to further question him as to the nature of the sexual

violence that he experienced or believe that he has no credible claim for refuge. If he is unable to answer these triggering questions, it could lead to his story being seen as untrustworthy. In cases such as this hypothetical example, the male refugee experiences a testimonial injustice because the IRB member does not believe his account of trauma and does not understand how his PTSD makes him unable to respond.

There is also a lack of collective hermeneutical resources available when it comes to men discussing their experiences of sexual violence. As previously discussed in chapter 4, there is an inability of both survivors and physicians to discuss male sexual assault. The stigma surrounding male sexual assault and the inability of this refugee and physician to discuss it results in the male refugee not being identified as a survivor, and therefore not being able to access support services for any related conditions such as PTSD or depression.

In addition to the belief that men do not experience trauma comparable to women, there are other negative stereotypes assigned to men that they must face when immigrating. There is a persistent stereotype that men are more prone to commit violence. A study of social media in 2015 showed that male refugees from Syria, and from the Middle-East in general, are commonly seen as terrorists, as a general threat to society, or as rapists who are a danger to women (Rettberg & Gajjala, 2016). These stereotypes are present outside of social media as well and were documented by Brun in the CARE report on men and boys in refugee contexts (Brun, 2017). Muslim and Arab male refugees are seen as potential security risks, and young single male refugees from Syria or Afghanistan are more likely than female refugees to be perceived as a threat to the security of host countries (Brun, 2017; Hodge, Hallgrimsdottir, & Much, 2019). As opposed to female refugees, who are viewed as victims of discriminatory cultural attitudes, men

are seen as “perpetrators of ‘uncivilized’ masculinities in need of reform” (Brun, 2017, p. 15). Brun also notes that this can impact who receives support for their mental disorder. While behaviour in women is recognized as symptoms of a mental disorder, those same behaviours for men are seen as a problem for the rest of the community, instead of an individual in need of support (Brun, 2017). When these stereotypes are combined with the stereotypes that are applied to certain mental disorders, such as schizophrenia or personality disorders, male refugees with mental disorders could experience even more difficulty immigrating. The stereotypes and prejudices that exist for this intersectional identity could lead to a male refugee with schizophrenia being more vulnerable to testimonial injustices in the immigration process, where immigration officials may fail to listen to his testimony and will instead deem him a threat to public safety. This testimonial injustice could increase the likelihood of him being placed in detention until his case is settled.

For female refugees, there may be cultural differences that impact their immigration process. For example, in Begum’s story, she found it difficult to discuss her experience of sexual assault with a male physician because of cultural differences and thought that the male IRB member conducting her interview would not be able to understand her experiences of sexual assault. This could impact how much women feel comfortable disclosing, and as seen in the case of Begum, could result in them being deemed as a not credible applicant and subsequently being deemed ineligible to immigrate. Similarly, female refugees may be uncomfortable having their IME performed by male physicians, but because of the regulations regarding who can be a panel physician, they may have no choice in the matter about who conducts their medical exam.

For refugees with mental disorders who are claiming asylum on the basis of their sexual orientation or gender identity or expression (SOGIE), harmful stereotypes surrounding gender further increase the likelihood of them experiencing an epistemic injustice. Despite its history of refusing refugees based on sexual and gender identities, Canada is now one of the top countries for LGBTQ refugee resettlement and allows people to claim asylum based on SOGIE (Jacob, 2020). The IRCC has also recently created guidelines for the treatment of LGBTQ refugee cases at the IRB hearing, with the goal of promoting greater understanding of the harm that individuals may face due to their deviation from what is considered 'normal' gender and sexuality expression (Immigration and Refugee Board of Canada [IRB], 2017). These changes do not negate the injustice that many trans and gender non-conforming (TGNC) refugees experience when immigrating. A 2019 review of the implementation of these guidelines showed middling results. One half of the RPD and RAD members who responded to the survey believed that the guideline had a beneficial impact on how they approached and adjudicated SOGIE cases. The other half of members responded that the guideline had not changed how they adjudicated these cases, or that they felt the guideline was not needed or created challenges when carrying out credibility assessments (IRB, 2019b). Of the 22 interpreters who completed this survey, 11 indicated that they had worked with SOGIE diverse individuals and, of these, five said they had applied the guidelines (IRB, 2019b). The review also mentions that the majority of interpreters did not receive training on the guidelines. Of the five designated representatives who responded, four of them had positive feedback. However, one indicated that IRB members "continue to rely on stereotypes or to make inappropriate assumptions" and "that they did not see a change in approaches to proceedings involving SOGIE-diverse individuals" (IRB, 2019b).

There was also concern that there is variation in how the guideline is applied, with some members still utilizing approaches that negatively affect SOGIE-diverse individuals (IRB, 2019b). Even when IRB members stated that the guideline was considered while making their decision, it was not always evident that it was applied in practice (IRB, 2019b). Notably, no SOGIE refugees are listed amongst the stakeholders who were consulted on the implementation of the Guideline, despite being the people who are arguably best placed to comment on the guidelines' impact.

If a TGNC refugee experiences epistemic injustice this may have a significant impact on their refugee claim, as it is based solely on how credible an IRB member or migration officer judges it to be. In order to be believed by the interviewer, they often have to change how they present their story such that their sexual orientation or gender identity is in line with western standards of sexuality and gender (Berg & Millbank, 2009; Lee & Brotman, 2011, 2013; Rehaag & Evans Cameron, 2020). This can mean relying on Western stereotypes of gender so that the IRB member or migration officer can better understand them. However, if a SOGIE refugee fails to conform to these stereotypes, or feels uncomfortable doing so, their claim may not be fully believed. Another issue that may arise is that SOGIE refugees are often required to give in-depth descriptions of their experiences of trauma and discrimination, which can be very difficult for people who have often had to hide their identity from everyone around them.

Going through this intense process of repeating the trauma they have experienced and attempting to conform to Western stereotypes of gender can be even more difficult for SOGIE refugees with mental disorders. As transgender people have elevated risks of mental disorders (as a result of higher stigma, discrimination, structural violence, and trauma), this can result in

even greater risk of experiencing an epistemic injustice (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Fredriksen-Goldsen, Cook-Daniels, et al., 2014; Fredriksen-Goldsen, Simoni, et al., 2014). If they are unable to repeat an experience because it is triggering or find it difficult to discuss their sexuality which they have hidden their entire lives, an IRB member or migration officer may doubt the validity of their entire claim. Similarly, for SOGIE refugees who have autism or another mental disorder that makes them less aware of social norms, it may be more difficult to conform to what a Canadian IRB member or migration officer believes constitutes a non-binary gender experience.

Credibility determination is poorly understood, even by decision makers themselves. In the case of refugee law, the differing life experiences of refugees and decision makers can make judgements based on "common sense" or intuitions less reliable when it comes to discerning truth from fiction (Rehaag, 2017). Because the question of "is this person telling the truth" is such a large and encompassing question, many IRB members will instead use heuristics such as "has the story changed from one telling to another" or "is the story consistent" (Jacob, 2020). This means that for SOGIE refugees with mental disorders, they need to tell the same story every time they give a testimony, with the same level of detail, or else their credibility will be called into question. Some mental disorders make it very difficult to do so, and as result means that SOGIE refugees may be more vulnerable to experiences of epistemic injustice.

5.1.2: Age

A refugee's age might also impact their experience with epistemic injustice. The number of child refugees is alarming, and there has been an increasing trend in the number of child migrants over the past 15 years, increasing from 25 million in 2005 to 33 million in 2018 (United

Nations Children's Fund [UNICEF], 2020a). Between July and September of 2020, a quarter of newly arrived refugees and migrants in Europe were children, with over 10,000 children being unaccompanied or separated from their families (UNICEF, 2020b). Children have been shown to be affected by traumatic experiences differently than adults. For example, while adults usually experience a decrease in symptoms of mental disorders after a period of detention, children may experience effects over a much longer term (J. Cleveland & Rousseau, 2013; Nair, 2019; von Werthern et al., 2018). A major concern when it comes to children is that they are treated with respect and given the credibility they deserve. If a child has a mental disorder, the likelihood of their concerns being dismissed as being overreactions, or their requests for accommodations not being taken seriously, further increases. Peled et al. compared the perceived credibility of children with a mental disorder and a neurotypical child. The study compared how a fictitious neurodiverse child, who had a chronological age of 15 and a mental age of 10, was perceived in comparison to a fictitious neurotypical child with a chronological and mental age of 15. Their results showed that while children are typically seen as less credible than adults, the neurodiverse child was seen as less credible than the neurotypical child of the same age (M. Peled, Iarocci, & Connolly, 2004). Their study also showed that the neurodiverse 15 year old child was seen as less credible than a 10 year old neurotypical child, even though participants of the study were told that their cognitive functioning was comparable (M. Peled et al., 2004). This suggests that simply knowing someone is neurodiverse can impact the credibility they are assigned.

Because children are inherently seen as less credible than adults, the knowledge that they have a mental disorder could further negatively impact the perception of the testimony

they give. If a 15 year old refugee with depression is giving testimony about their experience, but they are unable to accurately recount parts of their journey, they may be viewed as less credible both because they are a child and because of their mental disorder. These negative biases may be even more harmful for unaccompanied young boys, who are often seen as more dangerous as opposed to young, unaccompanied girls (Brun, 2017). As I will discuss later, children are also automatically assigned a designated representative when they are going through the immigration process, which could result in their testimony being ignored in favour of their representative's, thus exposing them to epistemic injustices.

5.1.3: Type of Mental Disorder

Another issue that can be illuminated by the concept of intersectionality is how some mental disorders may inherently lead to decreased credibility being assigned to those who live with them. Mental disorders such as schizophrenia, bipolar disorder, and other psychosis-causing or reality-affecting disorders, come with the prejudice that people who live with them are less trustworthy. This situation is reflected in the experiences of Uday, an asylum seeker with schizophrenia, who was detained upon arrival to Canada because he was unable to confirm his identity or country of origin. Uday felt that his schizophrenia made it more difficult for him to get out of detention (Gros & van Groll, 2015). His counsel also noted that:

> "'His mental health condition played a large role in his inability to confirm his identity, and also posed a larger barrier to securing his release due to concerns about his access to treatment.' … Uday 'consistently provided background information about himself to CBSA that turned out to be false or unverifiable. CBSA claimed that he was wilfully misleading them and frustrating their investigation into his identity… he is mentally ill and that has to account, at least in part, for his inability to confirm aspects of his personal history and identity. A proper appreciation of his particular illness would not include the unreasonable expectation that he provide reliable and consistent historical information.'"

(Gros & van Groll, 2015, p. 62)

There is evidence suggesting higher incidence of schizophrenia and other mental disorders which cause psychosis among refugee populations compared to native and non-refugee migrant populations (Brandt et al., 2019; Hameed et al., 2018; Kirkbride & Hollander, 2015). The stigma surrounding mental disorders like schizophrenia creates opportunities for epistemic injustice, for example, in the context of the IRB interview, where the purpose of the interview is to evaluate whether this person should be allowed to remain in Canada as a refugee. In this situation, the consequences of testimonial injustice could lead to a person's entire interview being discredited. This issue is difficult to approach, and this paper cannot present a final solution for it. However, consultation with advocacy groups as well as with refugees with schizophrenia or other psychotic disorders will help to increase awareness about these disorders and will work towards including people with these disorders in answering this question. More work needs to be done in this area so that these epistemic injustices can be address. The inclusion of refugees with mental disorders is necessary in order to respond with the nuance that this problem requires.

5.2: Designated Representatives

Another set of policies that create instances in which there may be cases of epistemic injustice is when a designated representative is assigned to a refugee for their immigration process. A designated representative is appointed by an IRB member when the person who is the subject of the proceedings is either a minor or an adult who is unable to appreciate the nature of the proceedings (IRB, 2018b). A person is unable to appreciate the nature of the proceedings if they "cannot understand the reason for the hearing or why it is important or

cannot give meaningful instructions to counsel about [their] case" (Gros & van Groll, 2015, p. 59). The designated representative is responsible for protecting the interests of that person, as well as explaining the process to them. In the case of an adult who is unable to appreciate the nature of the proceedings, the representative may be a family member, a friend, or a worker from an agency that provides such services (IRB, 2018b). In Chairperson Guideline 8 which deals with vulnerable groups, this "may include, but would not be limited to, the mentally ill, the elderly, victims of torture, survivors of genocide and crimes against humanity, women who have suffered gender-related persecution, and individuals who have been victims of persecution based on sexual orientation and gender identity" (IRB, 2018). The Guideline then continues to say that at the discretion of the IRB member, designated representatives will be assigned to vulnerable people who are (in the opinion of the member) unable to appreciate the nature of the proceedings (IRB, 2018). Based on these guidelines, it is likely that some refugees with mental disorders would be designated as such, for example, people with autism or psychotic disorders. This assumption is given further credence in the Guide to Proceedings Before the Immigration Division, which states that "medical reports concerning the mental state or intellectual ability of the person concerned; or difficulties noted in meetings or discussions with the person concerned before the hearing" can warrant the use of a representative (IRB, 2005).

The provision of a designated representative can be seen in both a positive and negative light. In negative scenarios, having a designated representative assigned to someone has the potential to impede a person's testimonial autonomy and expose them to epistemic injustice. A representative's responsibilities include making decisions regarding the case or assisting the applicant to make those decisions (IRB, 2018b). Some issues identified by legal counsels who

work with refugees include designated representatives being unhelpful, such as failing to do preparatory work, or potentially never meeting with or speaking to their client, with some not even speaking the same language as the person they are supposed to represent (Gros & van Groll, 2015). One testimony from Uday, a detained asylum seeker commented that he hated his representative:

> "'I hate this guy… he never gave a shit… one time he asked for an early detention review… but he never came. I waited for him. He never came.' When the DR did attend the detention reviews, it was Uday's perception that 'he was not helpful' and 'never sorted it out.' Uday considered the [designated representative] to be an employee of the CBSA who would do whatever CBSA told him to do."
>
> (Gros & van Groll, 2015, p. 62)

It is easy to see how the testimony of a person with a mental disorder such as autism could be assigned less credibility than their representative's testimony. Because they have been assigned a representative on the grounds that they are unable to appreciate the immigration process, their representative speaks for them, makes decisions for them, and essentially navigates the entire process for them. The Guide to Proceedings suggests that the designated representative should explain and include the represented person as much as possible, but notes that "a person who is unable to appreciate the nature of the proceedings and who suffers from a temporary attention deficit should be consulted more than a person who has a serious cognitive impairment" (IRB, 2005, pp. 7-3). Thus, the decision on how much to involve a represented person depends on the subjective judgement of the designated representative. This could be impacted by stereotypes of mental disorders, leading to the infantilization of refugees with mental disorders and the overall dismissal of their opinions and voices.

There also does not seem to be any checks in place to ensure that people who are assigned representatives are given the same level of credibility as those who are not assigned one. When discussing the role of the designated representative, it is stated that "persons who are unable to appreciate the nature of the proceedings may also have some ability to participate in making decisions, depending on the type of decision that has to be made and the nature and severity of their impairment" (IRB, 2018b). The wording of this statement suggests that in most cases the designated representative will make decisions regarding the case of the refugee, especially for important decisions in the application. While there have been debates about what level of capacity necessitates the removal of autonomy when it comes to decision making, this claim also fails to take into account neurodiversity (Cascio & Racine, 2019; Devi, 2013). People who are neurodiverse make decisions differently than people who are neurotypical. For example, someone with autism may process information on a more local level, rather than at the global level or 'seeing the whole picture' like neurotypical people. This difference in decision making can result in autistic and neurodiverse people being labelled as impaired. In psychological studies, differences between autistic and non-autistic control groups were explained by a cognitive impairment associated with autism, even when the autistic group outperformed the control group (Craigie & Bortolotti, 2014). This assumption carries over into how capacity is assigned to people, such that characteristics of autism are interpreted to have "an incapacity because of their abnormal rationality relative to the general population" (Craigie & Bortolotti, 2014, p. 400). In cases such as this, where someone does not account for how neurodiversity can impact how people interact with others, they may falsely assume that a refugee with a mental disorder is incapable of understanding what is happening around them. This greatly increases

the possibility of testimonial injustice. If they are viewed as incapable, then their testimonies could be disregarded in favour of their representatives.

The use of designated representatives certainly can have positive effects for people. For children who are travelling alone it can help them to navigate the process and have an adult guiding them, and for people who are deemed 'unable to understand' the process, in some cases it can be very helpful. However, the system of assigning designated representatives is flawed, limiting potentially positive effects. One key issue with the system that prevents the possible positive impacts is the difficulties one can face with getting a representative. Their appointment relies on the discretion of the IRB member, and, as demonstrated by research conducted by Gros and van Groll, getting the member to believe that representatives are necessary can be very challenging (Gros & van Groll, 2015). More negative problems arise when representatives fail to promote the decision-making agency and active participation of someone with a mental disorder. An added difficulty is that the guidelines for assigning someone a designated representative are also very vague, and there is no definition of what is considered severe enough to warrant this aide. This process is one of the ways that refugees with mental disorders can experience an epistemic injustice, specifically a testimonial injustice. Of course, there is the other side of the coin, where having a designated representative could improve a refugee's ability to be heard and have their testimony respected. In this regard designated representatives can help promote epistemic justice.

5.3: The Immigration System & the Cycle of Epistemic Disenfranchisement

So far in this chapter I have discussed where epistemic injustice might occur in the Canadian immigration system. I would now like to turn to a new concept, one that looks at how

stand-alone moments of epistemic injustice can contribute to a larger, more systemic-level cycle of epistemic injustice. By examining other forms of epistemic injustice such as epistemic exclusion, epistemic privilege, epistemic oppression, and epistemic violence, we are able to better understand how refugees with mental disorders are more likely to face epistemic disenfranchisement.

To begin, refugees with mental disorders are more likely to experience epistemic exclusion from epistemic spaces that they would benefit from being included in. One example of the exclusion of refugees with mental disorders from contributing to epistemic spaces is the external audit of detention practices in Canada, which failed to include refugees in the review process. Despite closely following the detention and appeal process of 18 individuals between 2010 and 2017, the auditors never directly interacted with the refugees who they were observing, nor did they discuss detention practices with any refugees who had previously been detained (IRB, 2018c). This audit never consulted the refugees themselves on the outcome of the audit, nor were they consulted during the interpretation of their experiences. The report notes that while 14 of the 18 cases they followed ended in the deportation of the refugee, four refugees were approved to remain in the country. One way that this audit could have been more epistemically just, and broken this cycle of epistemic disenfranchisement, would have been to reach out to these four refugees and consult them during the preparation of this report. This would have included them in the audit process and would have ensured that their knowledge and experiences were taken into account by the auditors and interpreted correctly.

On the policy level, refugees with mental disorders also seem to be excluded. In the 2018 review of the IRB, despite various stakeholders being included in this review, there was no

mention of the inclusion of refugees or asylum seekers as stakeholders (IRB, 2018). Most stakeholders and experts were organizations, with some individuals being named. One organization which could have included refugees was the Canadian Council for Refugees, but when asked about the composition of their team at the time of writing, they did not respond. Although the inclusion of these organizations is admirable, the true experts and stakeholders in this process are refugees and asylum seekers who have first-hand experience of the immigration process. Instead, they appear to have been epistemically excluded from this process and not given the chance to contribute to improving the immigration system.

These examples suggest that refugees with mental disorders could be excluded from the epistemic space surrounding immigration policy. This exclusion is related to who is granted epistemic privilege. When it comes to the immigration process, epistemic privilege is typically granted to people who are said to be experts on it, such as immigration lawyers, refugee organizations, or others who work in the professional sphere. However, this privilege is often conferred to people who do not have direct life experiences of the process as refugees. If experiences are believed to create a better understanding than observation and second-hand retelling, then refugees, asylum seekers, and those who have undergone the immigration process are the true experts. But it is rare to see them given this epistemic privilege in the context of discussions related to the immigration system. Instead, because of pre-existing notions of expertise, the knowledge of people who hold prestigious jobs such as physicians, lawyers, and other professionals in the business of immigration is elevated and deemed more epistemically relevant. Therefore, refugees with mental disorders are not given epistemic

privilege when it comes to understanding the immigration process, despite their experiences and valuable insight.

The act of privileging one group of voices over another and controlling who is included in epistemic communities is closely linked to epistemic violence. Dotson notes that epistemic violence occurs in testimony when an audience is unable to communicate reciprocatively with the speaker because of an ignorance stemming from a gap in epistemic resources, which subsequently harms the speaker (Dotson, 2011). The two forms of epistemic violence that she mentions are testimonial quieting, where an audience fails to recognize a speaker as a knower due to stereotyping, and testimonial smothering, when a speaker modifies their testimony to only contain content that they believe their audience will be able to understand (Dotson, 2011). Constant epistemic exclusion and epistemic privilege can contribute to these forms of epistemic violence, as they can result in groups not being recognized as knowledge holders and can make members of marginalized communities truncate their testimonies to be deemed acceptable in spaces where they believe the audience may be not receptive to their knowledge. Testimonial smothering can be seen in SOGIE refugees having to present their testimony in the IRB interview such that it conforms with Western stereotypes of gender, crafting their testimony in a way that the IRB member can understand their reason behind claiming refuge in Canada. Another example comes from Begum's story, where she deliberately left out her experience with sexual assault because she believed her audience to be incapable of understanding it (Cleveland et al., 2014). Additionally, as previously mentioned, there is a lack of shared hermeneutical resources between refugees with mental disorders and professionals in the immigration system, leading to further ignorance regarding the harms of the immigration system on refugees with mental

disorders. As Dotson puts it, "... we all need an audience willing and capable of hearing us. The extent to which entire populations of people can be denied this kind of linguistic reciprocation as a matter of course institutes epistemic violence" (Dotson, 2011, p. 238). When immigration officials, IRB members, and other professionals involved in the immigration system are not able (or are perceived to not be able) to understand the testimony of a refugee with a mental disorder or fail to recognize them as knowledge holders, refugees with mental disorders could potentially experience an epistemic violence. This is most likely not the intention of those making the choices to not include refugees with mental disorders as stakeholders, or the intention of professionals in the system. But as a result of consistent exclusion and devaluing of their voices, refugees with mental disorders are exposed to epistemic violence.

These failures to include and listen to the voices of refugees with mental disorders contribute to further epistemic oppression. Because they are initially excluded from contributing to the epistemic community, they are not granted epistemic privilege despite their first-hand knowledge, and they are unable to reciprocally communicate with people throughout the immigration process. Thus, the idea that they cannot contribute to the epistemic community surrounding immigration is a self-fulfilling prophecy. Refugees with mental disorders are barred from contributing to this space because in the past they were not seen as contributors, or were blocked from contributing, and as a result their voices and opinions cannot be heard in the present. This significantly hinders their ability to take part in knowledge creation and revision, and essentially ignores their first-hand experience of navigating the immigration system.

These developments of epistemic injustice help illustrate how eventually the cyclical nature of epistemic injustice can lead to the epistemic disenfranchisement of groups. By creating

a system in which certain groups are consistently excluded and others are consistently given an epistemic privilege, over time these dynamics become normalized. It can also contribute to hermeneutical injustice, as constant epistemic disenfranchisement does not allow for the creation of epistemic resources, nor does it allow for recognizing the lack of these resources, or the resources of marginalized or 'non-dominant' groups. This can result in certain groups experiencing epistemic disenfranchisement, where marginalized groups are consistently seen as having a lower epistemic status, and have to work against epistemic privilege, oppression, and violence in order for their voices to be heard. Epistemic disenfranchisement results in marginalized groups being automatically excluded from epistemic spaces, as unfair distribution of or access to epistemic resources has lead to the false and discriminatory idea that specific groups are unable to contribute in epistemic spaces at all.

In order to combat this cycle of epistemic disenfranchisement, there needs to be concrete action taken to include marginalized groups in epistemic communities. In the context of this project, including refugees with mental disorders, as well as the broad inclusion of refugees and refugees with disabilities, will aid in the creation of an immigration system that is more epistemically just and accommodating for everyone. I hope that this project encourages others to continue this line of research and will contribute to creating a more epistemically just space for refugees with mental disorders.

5.4: From Epistemic Injustice to Epistemic Justice

Having discussed epistemic injustices and epistemic disenfranchisement at length, I would now like to turn to their foil, epistemic justice. In some of the places where epistemic injustice occurs, epistemic justice is also possible, and is especially needed. As previously

mentioned, designated representatives are one such opportunity for the promotion of epistemic justice through the use of constant reflection on one's prejudices and actively working to correct these prejudices (Fricker, 2007). A designated representative could work towards epistemic justice by using the supported decision making model with the refugee they are working with. Instead of simply making decisions for them, the designated representative and the refugee would work together to find the best path forward (Cascio & Racine, 2019; Devi, 2013). In this way, a decision is reached that has included the refugee throughout the entire process and maintains their autonomy, and the designated representative has fulfilled their duty to help the refugee navigate the immigration system.

Epistemic justice could also be promoted through increased transparency and clarity regarding these elements. Better defining when a designated representative is necessary, what limits there are to the role, and the weight that their decisions have in comparison to the refugee they are working with would help to create a more defined position. Designated representatives have the opportunity to enact epistemic justice by listening to the refugees they work with, and by amplifying their testimony to the IRB. In this situation, they have the ability to correct their own prejudices and challenge any prejudices that an IRB member might have and could aid in promoting the credibility of the refugee they work with.

Another example of how epistemic justice is promoted in the Canadian immigration system can be seen in the implementation of the IRB's guidelines regarding vulnerable populations. Guidelines have been written that help guide the treatment of refugees who are women, children, SOGIE claimants, or are deemed vulnerable by the IRB, which specifically includes people with mental disorders (such as persons who have a mental disorder, minors,

elderly, or are survivors of genocide, etc.) (I. a. R. B. o. Canada, 2019a). These guidelines present various procedural accommodations that can be offered in the IRB interviews. They also present an opportunity for people to practice epistemic humility. In the case of SOGIE refugees, IRB members can acknowledge that they may not fully understand their conceptualization of gender and sexuality and could instead learn about it from them. This could also help to create an environment where SOGIE refugees are more comfortable sharing their experiences and could contribute to creating policy that is more understanding of issues SOGIE refugees face. Sensitivity, critical self reflection and respect are an example of how epistemic justice can be promoted in the immigration system.

Additionally, including refugees in review processes or system audits could enable them to influence future changes to immigration policy. Furthermore, their participation would help to better understand the impact that the immigration process has on refugees. By doing so, more professionals in the immigration system may be made aware of the reality of refugees with mental disorders in the immigration system, causing them to change how they view certain aspects or behaviours. Making these changes to the system promotes the inclusion of refugees and acknowledges their experiences and is one way that epistemic justice could be created in this system. The suggestions that I present below are further changes that could be implemented to make immigration to Canada a more epistemically just process.

5.5: Future Directions

As I said above, my original idea for this project was to conduct interviews with refugees with mental disorders, who have actual experience when it comes to this topic. However, because of COVID-19, I made the decision to pivot to a theoretical project and contribute to the

theoretical understanding of epistemic injustice in the immigration system in Canada. An important next step in this research is to conduct these interviews and to learn about the topic of epistemic injustice from refugees with mental disorders. These interviews could help to identify where and how epistemic injustice arises in the immigration process for refugees with mental disorders and would further support changes to immigration policy. At the very least, it could help to promote awareness of the need for accommodations for refugees with mental disorders, and better support their needs throughout the immigration process.

Overall, more research is needed regarding refugees with mental disorders and refugees with disabilities in general. Throughout my research it became apparent that this is an emerging field of study. When I was asked by colleagues about the number of disabled refugees worldwide I was not able to respond with confidence. One issue is that mental disorders are often invisible to others, and so refugees with mental disorders are not counted by officials in refugee camps or immigration officers. Another issue is that stigma surrounding mental disorders, both in Canada and in other countries, makes people more hesitant to disclose that they have a mental disorder. And a third issue is how many health professionals subscribe to the Westernized view of mental disorders and fail to take into account cultural differences. As a result of these issues, the prevalence of mental disorders in refugee populations is unknown.

In considering possible next steps for such research, I would propose that a wide range of mental disorders should be included as the experiences of refugees with mental disorders is not a monolith. The experiences of refugees with PTSD, depression or anxiety is very important, but so are the experiences of refugees with schizophrenia, personality disorders, or autism. As mentioned above, the negative stereotypes assigned to mental disorders like schizophrenia and

personality disorders is a strong argument to include the experience of refugees living with these disorders. The question of how to balance believing the experiences of refugees with psychotic disorders while also acknowledging that their perception of reality may not be accurate is a difficult one. But more needs to be done to support refugees with all types of mental disorders, no matter what the preconceived notions surrounding them are, as their experiences of epistemic injustice will be incredibly diverse.

Additional lines of inquiry relate to other migrant groups such as undocumented people and stateless peoples. Because of their precarious position in society, they may be even more likely to experience injustices. I talked about asylum seekers in my thesis, but it would be beneficial if future interview based projects included stateless people, undocumented people, and others living in the margins of this system, whether it be during or after their claim is processed. Their journeys through the immigration system is vastly different from government assisted or privately sponsored refugees, and it is important to support both those going through the process via official and non-official channels.

Finally, while it is important to address and educate individuals working in the immigration system who may be inadvertently contributing to epistemic injustice, it is also necessary to examine the structures that allow these injustices to occur. As Anderson notes, "help will therefore tend to be maldistributed, being heaped on salient, highly publicized cases of episodic catastrophe while neglecting more pervasive, persistent, and entrenched sources of disadvantage" (Anderson, 2012, p. 164). While it may be tempting to respond to individual cases of injustice, there are bound to be many more instances of people subjected to epistemic injustices if the underlying structures that allow these injustice to occur remain in place. The

education and training of those involved in the immigration process will create more just systems for people to operate in, and thus help to prevent epistemic injustice from occurring. By "[scaling] up the virtue of epistemic justice to systemic size", or by expecting the systems that we work in to operate in an epistemically just manner, we can examine the immigration system in such a way as to promote epistemic justice (Anderson, 2012, p. 165).

This discussion and analyses of gender, age, type of mental disorder and other points as it intersects with epistemic injustice stemming from mental disorders is just the beginning of what I hope is a robust investigation into the Canadian immigration system. Despite there being a lack of research surrounding refugees with disabilities in general, I believe it is clear that so much more can be done to accommodate their immigration to Canada. If we change the system and make it more accommodating for neurodiverse populations and increase training for professionals in the system, we can work towards creating an environment where people are treated as epistemic equals. No one should be seen as untrustworthy for a mental disorder which they cannot control and is of no fault of their own, and we deserve to be seen as equally credible by those who are neurotypical. We can do so much more to support refugees with mental disorders, by listening to their experiences and taking into account their knowledge of the immigration system, Canada can make changes to create a more epistemically just immigration system.

5.6: Reflecting on this Research

While conducting this research, I became more aware of my own position within this epistemic field (that of immigration and mental disorders). I am a white Canadian citizen, who has been privileged enough to access higher education. I am also someone with a mental

disorder, which has impacted my work on this thesis, throughout my undergraduate degree, and has in some ways brought a lot of stress into my life. In the past few years, I have become much more involved in the neurodivergent community, learning about how mental disorders can impact people's lives, and how being neurodivergent can be both a point of pride as well as a source of frustration. When I heard that a colleague was researching how disabled refugees experience the immigration process, I knew that I wanted to conduct a similar project. I have always been passionate about promoting the rights of refugees and immigrants. As a teenager I worked closely with the Association for New Canadians, an organization that helps to resettle new immigrants and refugees in my community, and I saw both the barriers that can arise for immigrants as well as the courage and resilience that they meet them with. I also knew that I wanted to focus my project on mental disorders, both because of my connection to the neurodivergent community, and because mental disorders can often be overlooked due to their 'invisibility'.

Another reason I decided to pursue this topic was because of my belief in the social model of disability. This model suggests that it is not any physical or mental impairment that leads to a person's disability, but rather the environment which they are in. For example, a person who uses a wheelchair is only disabled because there are no ramps or elevators in a building, not because they cannot walk, or a deaf person is disabled because no sign language interpretation has been provided at an event, not because they cannot communicate. For people with mental disorders and neurodivergent people in general, understanding and accommodating for different behaviours is key to navigating the environment we're in. I would have had a much harder time writing this thesis if my supervisor had not been so understanding and supportive

(thanks Matt). And so when I was thinking about my thesis, I knew that I wanted to look at how the environment of the immigration process was not accommodating for refugees with mental disorders and could instead create barriers and injustices.

When looking at the aspects of my identity that I have listed here (white, Canadian citizen, educated, etc.), I definitely seem to have more in common with professionals in the immigration system than the refugees who are navigating it. However, I also have experienced firsthand how difficult it can be to live with a mental disorder, and how many people do not take that into consideration. My hope going into this project was that I could elevate the voices of people with mental disorders who had actually experienced immigrating to Canada and could use my privilege to make a difference.

Due to the COVID-19 pandemic this was not exactly possible, and this project shifted from an interview-based project to a theoretical one. I believed, and still believe, that asking vulnerable people to make time to do an interview with me, especially when the neighbourhoods in Montreal with the largest refugee populations are the hardest hit by COVID-19, would not be fair, nor would recruitment be easy. Despite my best intentions, I recognize that this decision effectively silenced the voices of refugees with mental disorders who could have told me the story of their immigration and their potential experiences with epistemic injustice. As a result, all of the interpretations and instances of epistemic injustice that I identified in this thesis are based on my analysis of the immigration guidelines and second-hand sources. It is also very likely that I have overlooked instances of epistemic injustice that I could not identify because of my lack of experience. Despite my best intentions, I am still "lovingly,

knowingly ignorant" on the issues that I have written about because I am part of a more dominant 'collective' knowledge group (Mason, 2011; Tuana, 2017, p. 131).

Despite our mental disorders being one of the only things connecting me to the people that I have talked about throughout this thesis, I have tried to represent the possible injustices that they may face in an accurate and respectful way. One quote in particular that I read near the beginning of my research process helped drive home the importance of reflexivity on my part. While I was reading Aragon's paper, his comments on epistemic oppression helped me to reflect on how I may be contributing to epistemic injustice myself. He writes:

> We should first ask ourselves if the way we currently exercise our epistemic agency - the way that we participate in social processes of knowledge production - restricts the agency of others. Additionally, we should ask if we derive and enjoy epistemic privileges as a consequence of the restriction of someone else's epistemic agency. Do we silence, marginalize, exploit, or render powerless the voices of women in the global South through the exercise of our epistemic agency in discussing their situations? Do we enjoy greater epistemic opportunities and resources to discuss their situations by restricting their agency? Or do our actions of speaking for relieve, to some extent, the constraints on their agency?
>
> (Aragon, 2019, pp. 18-19)

And it is true that I may currently be silencing the voices of others. This is the major limitation of this project, both because I may have inadvertently and unwillingly contributed to the epistemic injustices that I have tried to identify, and because without the knowledge of people who have experienced the immigration process I have had to use theoretical examples. This acknowledgement is a commitment to do better in the future, by creating more epistemically just projects. I hope that despite the imperfections, this project will start a conversation around this topic, and contribute to a foundation upon which more epistemically sound research can be conducted in the future with more diverse voices driving it.

Chapter 6: Conclusion

This research project was started with the goal of analyzing how epistemic injustice may arise for refugees and asylum seekers with mental disorders in the Canadian Immigration system and to draw attention to ways that epistemic justice can be advanced. Based on my analysis of the Immigration Medical Exam, immigration interviews, and various policies related to refugee immigration in Canada, it is likely that refugees and asylum seekers with mental disorders experience epistemic injustice at various points in their immigration process. During the IME and interviews with either migration officers or IRB members, interactions between the person in power and the refugee or asylum seeker could provide an opportunity for epistemic injustice, especially if the person in power lacks knowledge about mental disorders and their symptoms. Similarly, policies that lead to the detention of refugees promote stereotyping of mental disorders and could subsequently result in epistemic injustice. Various concerns about epistemic exclusion, epistemic oppression, epistemic privilege, and epistemic violence were also discussed.

Conversely, epistemic justice can be promoted through the recognition of refugee voices and knowledge, acknowledging them as stakeholders in audits or review processes, and providing accommodations and support services that make navigating the immigration system more accessible for everyone. In order to act in a way that is both testimonially and hermeneutically just, a person must address their own prejudices and biases and withhold judgements accordingly. Taking this a step further and practicing epistemic humility would require a person to be aware of their limitations, as well as engaging with people who hold different perspective and learning from them. This self awareness must be practiced by people throughout the immigration system, from CBSA officers who intercept asylum seekers entering

Canada, to the head of the IRCC. While changes on the personal level are important, it is also important to make structural changes. A range of actions could advance epistemic justice in this context. Refugees and asylum seekers with mental disorders should be included in the creation of policy that impacts them and should be consulted when they are revised. More training should be provided to members of the IRB or migration officers regarding mental disorders and how to accommodate them in interviews. Similarly, changes to the IME process such as allowing refugees to conduct the examination with a known physician instead of a stranger could improve the experience for refugees and asylum seekers with mental disorders. Finally, policies that promote the stereotyping of mental disorders such as section 6.4 in the Operating Manual for Detention, should be removed so that refugees and asylum seekers are not discriminated against for having a mental disorder. More broadly, the Canadian immigration system could become more epistemically just by shifting policy towards a more cosmopolitan understanding of global justice. Regardless of whether asylum seekers are accepted as refugees to Canada, or whether refugees' claims will be approved, Canada has the means to provide support to them throughout the immigration process. Compassion for those in need should not be restricted to only those who have been accepted as refugees to Canada.

This project has started the process of identifying where refugees and asylum seekers might experience epistemic injustice in the Canadian Immigration process, but more work needs to be done. I look forward to seeing future contributions to this field, and to working to make the Canadian immigration process a more equitable experience for refugees with mental disorders. Suggestions for future research on this topic begin with the inclusion of refugees and asylum seekers with mental disorders in the projects. Ideally, they would be involved from the

conception of the project to the end of it. Interviews with refugees with mental disorders is an important first step in this process, so that their experiences and knowledge on the immigration system is recognized and respected. Following this, further investigation of how intersectionality impacts experiences of epistemic injustice could be a way to pinpoint more specific support, for example, for transgender refugees. Research could also look into what is the best way to implement policies that promote epistemic justice. For example, interviews could be conducted with refugees who immigrated before the introduction of the IRB guidelines, and with refugees who immigrates after them. This could provide information on whether they have made an impact on how refugees experience the immigration process. Research in this vein of inquiry could contribute to the more successful implementation of policies that promote epistemic justice. I hope that this project prompts a deeper inspection of the Canadian immigration system, such that it can be made more just for refugees who immigrate to Canada.

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