Theoretical Medicine and Bioethics
https://doi.org/10.1007/s11017-025-09730-5

Unmasking therapy-speak

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Received: 19 January 2025 / Accepted: 15 September 2025

Abstract
Therapy-speak is the imprecise and superficial integration of psychotherapy language into everyday communication, especially by privileged or wealthy people. Despite the advantages of normalizing psychotherapy language, such as resisting epistemic injustice and enhancing awareness of mental health issues, therapy-speak raises important concerns. On the epistemic front, therapy-speak is susceptible to the erosion of the meaning and relevance of psychotherapy terms, pathologizing, and the risk of self-diagnosis. Regarding its ethical concerns, therapy-speak might be used to discredit individuals, evade responsibilities, and even signal social status, by taking an objective stance. Beyond these epistemic and ethical concerns, therapy-speak can also be weaponized to promote and perpetuate some forms of epistemic injustice, and to generate affective injustice. In particular, we argue that the weaponization of therapy-speak exploits the epistemic authority and the credibility excesses of medical evidence, the conflation between the descriptive and the normative, and the linguistic strategy of deniability to impose a specific way to manage emotions in challenging, and unjust, situations.

Keywords Therapy-speak · Mental health · Epistemic injustice · Affective injustice · Epistemic authority · Evaluative language

Introduction

As accessibility to psychotherapy and mental health content grows, particularly in the digital age, a new communicative practice is emerging. Even outside of the therapy session, many are advised to 'set boundaries', 'hold space', and 'reject toxicity'. People are also warned about the dangers of "gaslighting", "narcissism" and "love bombing" in their relationships [1–3]. This way of speaking, especially performed and promoted by privileged people—e.g., people at the intersection between

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Published online: 30 September 2025

not experiencing mental health issues and belonging to a social identity with high social power, is permeating everyday conversation. People increasingly hear about 'toxic' people and 'abusive' and 'codependent' relationships, but also about 'coping mechanisms', 'traumas', 'anxieties' and 'emotional triggers'. People say they feel a bit 'depressed', have a bit of 'OCD', are a bit 'bipolar', and practice 'self-care'. This new trend in communication has garnered attention in the public discourse, particularly in social media, where it has been referred to as 'therapy-speak'.

While the incorporation of psychological and psychiatric vocabulary (henceforth, 'psychotherapy language') into everyday communication is beneficial, it risks facing a similar fate as other introduced terms [4]. Conceptual tools initially introduced to fight against particular injustices might be weaponized after gaining widespread acceptance in mainstream culture. In other words, these tools might end up being used to promote and perpetuate the very injustices they were intended to reduce, and in some cases, even giving rise to new forms of injustice. For instance, the expressions of 'woke' and 'being silenced', initially introduced by the disenfranchised to expose the abuses of the powerful and later also used by the powerful as an attempt to maintain their unjust privileges, might serve as examples [5]. Even more technical notions such as the concept of testimonial injustice introduced by Miranda Fricker [6] has been weaponized by political figures and used as part of a more complex strategy to covertly advance their political agendas [7–9]. In the context of mental health, terms used to describe the experiences of people with OCD (obsessive–compulsive disorder) are misappropriated to describe certain personality traits of people who do not have a mental disorder but are in more socially advantaged positions [10]. In this sense, therapy-speak can be seen as the counterpart to the positive normalization of psychotherapy language: it involves the imprecise and superficial use of this language, employed by the privileged without really caring about mental health, and often weaponized for manipulation.

Despite the growing interest in therapy-speak in the public discourse, there is no examination of its epistemic and ethical risks in the scholarly literature. The first aim of this paper is to fill this gap. In the second section, we define therapy-speak and illustrate it with some cases. In the third section, we elaborate on the main epistemic and ethical concerns of therapy-speak. After this, in the fourth and fifth sections, we connect the practice of therapy-speak to recent discussions on epistemic injustice, affective injustice, and mental health. In the fourth section, we argue that therapy-speak can be weaponized to promote and perpetuate some forms of epistemic injustice, and to generate affective injustice. In particular, we argue that therapy-speak exploits the epistemic authority and the credibility excesses of medical evidence, the conflation between the descriptive and the normative, and the linguistic strategy of deniability, to impose a specific way to manage emotions in challenging, and unjust, situations. More specifically, people in positions of power might use therapy-speak to invoke the epistemic authority of mental health experts, and thus hide value laden positions as if they were value free, to somehow force victims of oppression to deal with unjust situations in a very specific way that, at the end, perpetuates the very injustice they suffered. In the fifth section, we defend that such use of therapy-speak risks exercising affective injustice.

What is therapy-speak?

The first thing to note is that therapy-speak is not the mere integration of psychotherapy language into our regular linguistic exchanges. Rather, therapy-speak refers to a modern linguistic trend, a sort of linguistic practice, particularly present among privileged people, characterized by the *imprecise and superficial use of psychotherapy language*—originally developed by mental health professionals for clinical settings– in everyday communication by people who are not mental health professionals and whose main concern is *not* mental health, especially within online, social, and personal realms [2]. This imprecise and superficial use might stem from the misapplication, oversimplification, or both, of psychotherapy terms by these people in certain contexts. Misapplication, in this context, refers to the use of a psychotherapy term to refer to phenomena other than those it was intended to address. For instance, one misapplies the word 'trauma' if one uses it to refer to a mere negative childhood experience [11]. On the other hand, oversimplification entails reducing complex ideas to simple ones. For instance, clinical psychologist Lauren Cook warns that "social media boils down very complex situations and conversations into 30-s sound bites" [3]. Thus, therapy-speak is characterized by the use of psychotherapy terms to refer to experiences and situations that fall outside its intended scope, especially by privileged people who are not mental health professionals, and whose main concern is not mental health. Situations where someone claims they have a bit of OCD because a messy desk bothers them, or accuses another person of gaslighting them simply for having a different interpretation of an event, count as examples of therapy-speak. It is a kind of emerging linguistic practice that seems to be about mental health but is not.

Discussions over the ethics of therapy-speak in the public discourse particularly took off when clinical psychologist Arianna Brandolini shared advice on ending a friendship through a TikTok video [12]. She suggested phrases such as "I've treasured our season of friendship, but we're moving in different directions in life", or "I get that it might be hard to understand, but I've been reevaluating many areas of my life recently, including my ability to be a good friend to you". Although Brandolini, as a clinical psychologist, might not be using therapy-speak herself since her way of giving advice is similar to what she does in her professional practice, she is nonetheless encouraging others to use it outside of the therapy room, thus promoting therapy-speak. Despite Brandolini's claims that those kinds of phrasings are meant as a roadmaps or templates [12], the case has received significant mockery and backlash because of its artificiality and condescension [3, 12].

A famous case of therapy-speak in celebrity culture can be found in the leaked text messages between actor Jonah Hill and his ex-girlfriend, professional surfer Sarah Brady [1]. In the disclosed messages, Hill establishes what he categorizes as 'boundaries for a romantic relationship,' and demands Brady to refrain from activities such as surfing with men, or posting pictures in a bathing suit, among others. Hill's use of the concept of boundaries illustrates how psychotherapy

language has been assimilated into everyday conversation, and how it can be misused and even weaponized—shifting from an expression commonly used to describe the healthy limits individuals set to protect their emotional well-being, to one used to impose, in this case, misogynistic demands on others.

Depending on the terms used, therapy-speak can be categorized into two types: therapy-speak with clinical terms that refer to specific psychiatric diagnoses—e.g., 'OCD,' 'narcissist'–, and therapy-speak with non-clinical terms[1] that do not refer to psychiatric diagnoses—e.g., 'emotional trigger', 'coping mechanism', etc. The case of Hill represents an example of therapy-speak with non-clinical terms, as he uses the phrase 'boundaries for a romantic relationship' imprecisely and abusively. Both types of therapy-speak, with and without clinical terms, could be significantly harmful when weaponized, but the latter does not involve risks such as pathologization and stigma, which therapy-speak with clinical terms does.

As mentioned, therapy-speak might include not only the expressions and strategies of psychotherapy communication but also its clinical terms. For instance, the terms 'psychopath' or 'sociopath'—though not official clinical diagnoses, but rooted in clinical psychology and related to the official diagnosis of Antisocial Personality Disorder [14]– are often erroneously overapplied as a catchall explanation for atrocious behavior, and this misinterpretation is perpetuated by popular culture. Notably, even fictional villains such as Hannibal Lecter, Patrick Bateman, and Annie Wilkes do not align with the diagnosis of antisocial personality disorder [15]. Conversely, some psychiatric terms are often underapplied due to people's difficulty in recognizing their associated mental disorders [16–18]. For instance, when presented with vignettes of agents experiencing depression or schizophrenia, only 39.8% of the surveyed population correctly identified the condition, while 60.2% of them perceived it as a crisis [19]. Although it seems that recent mental health awareness efforts might have improved people's ability to recognize depression [18, 20], some mental disorders are still less well recognized, such as schizophrenia and anxiety disorders [18]. Consequently, therapy-speak with clinical terms might still lead to a significant misunderstanding of mental health conditions and contribute to the stigmatization.

Additionally, therapy-speak has been used to cover up workplace's problems, which has been referred to as "psychwashing" [21]. Companies and corporations increasingly express concern about their employees' mental health and well-being, but in some cases this is just a way of covering up deeper problems, such as overwork and layoff, instead of expressing real care about the mental health of their employees. For instance, a young lawyer who worked for a big corporation that spoke a lot about the well-being of their employees and work-life balance was, however, incredibly overworked and stressed, and frequently received sexist comments from her superiors. After she let her manager know about how she felt and was treated by her teammates, she was told that she needed to learn how to deal with such a situation, and was invited to join therapy sessions to learn how to do that. One of the role-play sessions included was titled "what to do when someone crosses your boundaries" [21]. Not long after, she fell into depression, and the company

[1] We are indebted to Pilar López-Cantero for this remark, and for referring us to her suggestions on her Twitter/X thread on the value of therapy-speak to deal with breakups [13].

did nothing to reduce her workload or ameliorate the work environment. The use of therapy-speak by companies and corporations illustrates a tendency to exploit mental health language to mask underlying issues rather than genuinely addressing employees' well-being concerns.[2] Again, therapy-speak is a linguistic practice, mostly performed by privileged people or institutions with power or influence, that seems to be about mental health but is actually used for something else.

To sum up, by examining cases such as the widespread use of terms like 'boundaries' or the corporate phenomenon of 'psychwashing,' in the next section, we aim to explore the epistemic and ethical concerns of therapy-speak. In the fourth section, we focus on how it can be weaponized to promote, perpetuate and even generate certain forms of injustice.

Epistemic and ethical concerns of therapy-speak

Before delving into the potential concerns of therapy-speak, we would like to emphasize that we do not oppose the popular use of psychotherapy language. The integration of psychotherapy language into our everyday language offers relevant advantages, such as resisting epistemic injustice and enhancing awareness of mental health issues. Indeed, gaining, creating and mainstreaming new concepts to articulate specific experiences can serve as a form of resistance for the disenfranchised against epistemic injustice [24]. Epistemic injustice is defined as the injustice of being systematically harmed as a knower due to belonging to a socially marginalized group [6], whether by being granted less credibility as an informant, by lacking access to relevant conceptual resources, or by being unjustly excluded from epistemic practices for reasons related to the victim's social identity. Historically, disenfranchised groups have been deprived of the necessary means to better understand and share with others their particular experiences, thereby perpetuating the very injustices they endure. For instance, the mainstreaming of a concept such as 'postpartum depression' has been crucial not only in bringing awareness to an overlooked aspect of mental health that some women face, but it has also provided women with the hermeneutical resources that they unjustly lacked to make sense of and share their experiences [6, p. 148–149], which in turn increases women's hermeneutical power—the capacity of a social group to understand and interpret their experiences and communicate them effectively.[3] The absence of certain concepts renders the experiences of some individuals invisible. As it is popularly said, if it does not have a name, it does not exist. But it is not only this. The lack of widely recognized conceptual resources also limits the possibility of experimenting and seeking alternative

[2] The use of therapy-speak in psychwashing is particularly worrisome given recent skepticism and concerns regarding the risks associated with universal mental health interventions, which are normally delivered to groups of people with different mental health needs [22, 23].

[3] For a skeptical view of the role of psychiatric terms in resisting hermeneutical injustice, see Solomon [25].

ways of managing certain situations.[4] For all these reasons, the generation of new concepts, as well as their mainstreaming, to enrich one's knowledge of the different ways of living and experiencing can count as a form of resistance against injustice. In this sense, the integration of psychotherapy language into everyday language must be understood positively, as proof that one is moving forward in the redistribution of epistemic power and justice.

On the other hand, this integration is particularly relevant in the realm of mental health. The lack of precise terms often leads to misunderstandings or dismissals of mental health challenges. Concepts such as 'postpartum depression', 'anxiety', 'depression', and 'post-traumatic stress disorder' have played a vital role not only in resisting epistemic injustice, but also in breaking down stigma and validating these experiences, contributing to what is commonly referred to as "mental health literacy" [31, 32]. By embracing and popularizing terms related to mental health, public stigma around it is reduced, even if the effect is small [33–35], and even if it depends on the sort of explanation of mental disorder that is favored [36]. Therefore, the popularization of psychotherapy language might be a crucial aspect both to resist epistemic injustice, and to challenge stigma around mental health.

Finally, there is nothing inherently negative about extending and broadening the uses of terms that were originally introduced to refer to a more limited set of situations. Psychotherapy language can serve many different functions, and therefore can lead to practices where these terms are used for other purposes. For instance, the term 'gaslighting' has expanded from its original interpersonal scope to describe more structural and collective practices [37]. Even the superficial and imprecise use of psychotherapy language in our regular linguistic exchanges—i.e., therapy-speak– might have potential benefits in specific cases. For example, using OCD-related language to imprecisely describe behavior somewhat aligned with clinical OCD could still help someone better understand themselves, even if it is a misdiagnosis. They might not have OCD, but recognizing certain behavioral patterns related to OCD, which they had not noticed before encountering the term, could be beneficial.[5] Additionally, this imprecise and superficial way of speaking could be beneficial in other situations where one might lack specific language, such as breaking up with a friend, as Brandolini observes [12].

Yet, therapy-speak is not just a practice resulting from broadening the uses of psychotherapy language. Rather, it involves the incorrect and superficial application of psychotherapy language to situations that do not fall within its original scope, under the assumption that they do, often from a position of privilege and without seemingly caring about mental health. In this sense, it always carries a cost in the long run, even if it can be beneficial in particular instances.

This last feature, the social position of the person using therapy-speak, is particularly relevant for our account: we assume here a language framework according to which a person's capacity to perform actions with their words—specifically, their

[4] As we acknowledge further in the text, hermeneutical injustice might come not only from a lack of conceptual resources, as Fricker [6] argues, but also from how the resources of the marginalized groups are used in relation to those of the dominant one [26–30].

[5] We thank an anonymous reviewer for this example.

ability to convey certain meanings and not others– depends significantly, although not exclusively, on their social power. Social power is shaped by the socio-normative position people hold within the social structure, which is partly determined by their social identity [38, 39]. For instance, a homeless person, someone with a distinctive accent, or someone from an underprivileged neighborhood have less social power than a middle-to-upper-class person, someone with significant social media influence, or someone with high social status. Hence, the former have less speech capacity than the latter. Thus, the fact that people with different identities use psychotherapy language imprecisely and superficially does not mean that they are engaging in therapy-speak in the same way: for marginalized people, therapy-speak might lead to mockery rather than being taken seriously.[6] Furthermore, the risks associated with therapy-speak are not the same for everyone. Individuals with disenfranchised identities and less social power are significantly more vulnerable to the epistemic and ethical dangers associated with therapy-speak. In contrast, those with greater social power can more easily use therapy-speak to retain their privileges. An example of this might be a person who uses therapy-speak to sell mental health care services framed as 'coaching' without proper training or education.[7]

That said, our primary focus in the following discussion is on the broader risks associated with this emerging communicative practice, particularly its impact on disenfranchised identities. Although therapy-speak, as said, might offer advantages in some cases, it raises important concerns, as illustrated by cases such as Jonah Hill's or the phenomenon of 'psychwashing'.[8] In what follows, we elaborate on both the epistemic and ethical concerns surrounding therapy-speak. On the epistemic front, therapy-speak is susceptible to the erosion of the meaning and relevance of psychotherapy terms, pathologizing, and the risk of self-diagnosis. Ethical concerns, on the other hand, center around its use to discredit individuals, evade responsibilities, and signal social status, by taking an objective stance. While these risks are interconnected, they will be addressed one by one for the sake of clarity.

Epistemic concerns

A first epistemic concern regarding therapy-speak is that through oversimplification, misapplication, or both, if influential enough in society, might erode the meaning and relevance of these terms for the ordinary user.[9] The idea behind this worry is that when a psychotherapy term is overapplied, its original depth and significance can be compromised, rendering it a mere linguistic shell. The consequence of such an erosion of meaning and relevance is a diminishing capacity for precise communication and an undermining of the nuanced understanding that psychotherapy language seeks to foster. For instance, when one uses the term 'OCD' not to refer

[6] We thank an anonymous reviewer for this point.

[7] We thank editor Cody Feikles for this example.

[8] A similar case is that of weatherman Nate Byrne, whose openness about his struggle with anxiety after experiencing a panic attack live on air not only sparked conversations about mental health [40], but also promoted therapy-speak around the concept of anxiety. We are indebted to Maureen Sie for this example.

[9] We are indebted to an anonymous reviewer for suggesting this phrasing.

to its clinical meaning—as a mental disorder characterized by intrusive, unwanted thoughts (obsessions) and repetitive behaviors or mental acts performed to reduce anxiety (compulsions) [14]—, but to describe certain personality traits, such as being tidy and organized, in people without such mental disorder, one contributes to limiting the conceptual tools available for individuals experiencing a distinct situation professionally denoted as 'OCD' [10].

Such erosion of meaning and relevance hinders the ability of those with psychological struggles to accurately convey and comprehend their specific experiences, resulting in specific forms of hermeneutical injustice. According to Fricker's [6] original conceptualization, a hermeneutical injustice occurs when people from a marginalized group lack the hermeneutical resources to understand and share significant aspects of their experience due to marginalization. Note that people suffering from mental health issues are particularly prone to marginalization, partly because of stigma and prejudice. As a consequence, they might not have enough social power to introduce new hermeneutical resources. Yet the forms of hermeneutical injustice arising from therapy-speak are better understood through other conceptualizations, which emphasize how the resources of the marginalized groups are integrated with and used in relation to those of the dominant one [8, 26–29]. In particular, the use of therapy-speak, particularly by the privileged, degrades the hermeneutical resources of those with mental health struggles, stripping away their inherent complexity and their underlying political context. As Marc Brackett says, "When we don't have the words for our feelings, we're not just lacking descriptive flourish. We're lacking authorship of our own lives" [41, p. 33]. Similarly, when one uses the word 'boundaries' to casually talk about one's preferences and desires, or to mean that one must deal with a given situation, one is depriving some people of more precise conceptual tools to fight against abuse. In the case of concepts with some moral content, such as 'gaslighting', their overuse might make them lose their normative force [4].[10]

A second epistemic, and practical, concern is therapy-speak's potential for pathologizing, if it is sufficiently validated. This is particularly the case for therapy-speak using clinical terms. People lacking professional training might not only misuse psychotherapy terminology; they might also overapply it and hence pathologize normal variations in human behavior or experiences.[11] In other words, phenomena belonging to entirely distinct categories, such as common reactions to

[10] A corollary of our analysis is that other cases of misapplication or oversimplification of scientific or technical terms are also prone to the erosion of the meaning and relevance of those terms, as long as such misuse deprives already marginalized and stigmatized groups from hermeneutical resources to make sense of their lived experiences. For instance, if people started to use the term 'chronic pain' to refer to everyday, minor discomfort, such as frequent sore muscles, this use could also generate hermeneutical injustice to those suffering from chronic pain conditions. These people often face marginalization, and misusing terminology in this way would deprive them of relevant hermeneutical resources to understand and share their experiences. Similarly, terms such as 'woke' or 'being silenced,' as discussed in the introduction, can also contribute to hermeneutical injustices. We thank an anonymous reviewer for raising this point.

[11] In this part of the text, we focus on the risk of pathologization in therapy-speak and the concerns that this raises for everyone in general, whether or not they are struggling with mental health. For a more specific analysis of the pathologization of emotions and how it harms those already struggling with mental health, see Lavallee & Gagné-Julien [41].

specific situations, may be at risk of being grouped under the extension of terms belonging to different types of categories. The epistemic implications of categories related to mental health differ from those associated with common reactions to certain situations. Blurring the lines between them poses the risk of pathologizing entirely appropriate behaviors. As a consequence, for instance, people might be led to categorize normal anxiety as a disorder [42], or shyness as a social anxiety disorder [43]. The flip side of the coin is that by pathologizing ordinary experiences, one might end up trivializing the experiences of those that deserve clinical support and undermining mental healthcare provision for them [10, 44]. By using the term 'OCD' to describe everyone with a set of personality traits, such as being tidy and organized, not only does one pathologize people with those personality traits, but one might also trivialize the real and sometimes extreme suffering experienced by those diagnosed with OCD. Consequently, people with OCD might not be considered as deserving of support, which might compromise their treatment. This phenomenon has been referred to as "wrongful de-pathologization" [10].[12]

Finally, there is the concern of self-diagnosis, especially in the case of therapy-speak with clinical terms. Because of the amount of mental health-related content on video-sharing platforms such as TikTok [45], people might attempt to apply psychotherapy terminology to themselves without the expertise of trained professionals [42]. Of course, this is not problematic per se. Diagnostic labels serve as a significant source of narrative, shaping individuals' self-concepts and influencing possibilities for self-development based on identified mental health conditions [46, 47]. As noted in the introduction, having a wider range of concepts available is usually beneficial, among other things because it helps one understand and better explain one's psychological and emotional experiences. Yet in the case of self-diagnosis, there are at least three risks. First, since therapy-speak is the imprecise and superficial use of psychotherapy language, there is the potential for misidentifying or overgeneralizing symptoms, which might lead to inappropriate self-treatment or unnecessary distress. Secondly, particularly in the case of therapy-speak using clinical terms, and given the predominance of the biomedical model in mental health care, therapy-speak risks reinforcing a narrow biomedical view of mental health. This perspective might lead people to perceive their mental distress in essentialist terms, and as purely a result of biological or medical conditions that fall beyond their control. This is problematic because it can overlook the broader environmental, social and cultural factors that contribute to mental distress. Notably, this risk persists even in cases where psychiatric diagnoses are accurate [47], and even when the models used to understand mental health are not the biomedical ones [46]. Finally, a specially harmful consequence of this self-diagnosis is that it might influence one's behavior in a way that exacerbates the symptoms [22, 23]. For instance, viewing mild anxiety as indicative of an anxiety disorder could prompt behaviors like avoidance, which

[12] Spencer and Carel [10] refer to this trivialization as a form of "wrongful de-pathologization" to emphasize that, although 'de-pathologization' is typically viewed positively (as in the case of the de-pathologization of homosexuality), it can also be harmful. In such cases, it might trivialize the suffering of those with a psychiatric condition and deprive them of the appropriate hermeneutical resources needed to share and understand their experience.

may intensify the anxiety over time. Consequently, therapy-speak might contribute to a looping effect [48], where increased labeling of distress leads to further symptom development, which in turn reinforces the perception of mental health issues, contributing to inflated prevalence rates of reported mental health conditions.

Ethical concerns

A first ethical concern, particularly related to the use of therapy-speak with clinical terms, is its potential for discrediting. Because therapy-speak is used by untrained people, it might not only misdiagnose others and pathologize non-clinical troubles, as we have mentioned, but it might also be used to discredit disenfranchised people's testimony, thus perpetuating and even exacerbating different forms of testimonial injustice. People with psychiatric diagnoses have been highlighted as particularly at risk of testimonial injustice, as their claims tend to be given less credibility because of stigmas related to mental health disorders [49–53]. In the context of therapy-speak, when untrained people label others with mental health disorders to discredit them, they risk perpetuating harmful stereotypes and biases. Moreover, by assigning a psychiatric label to someone without proper expertise, there is a danger of undermining their credibility and discrediting their experiences. This latter case does not constitute a case of testimonial injustice necessarily; yet, it can contribute to raising them.

A second ethical concern is the worry of responsibility evasion. As clinical psychologist Arianna Brandolini asserts, "People can take these words and concepts out of context and use it to justify bad behavior. It can also feed unhealthy self-centeredness" [3]. Therapy-speak can be exploited to justify selfish decisions, under the guise of compassion and understanding. A famous example of such weaponizing of therapy-speak is the previously mentioned case of actor Jonah Hill, who used the term 'boundaries' to impose and legitimize misogynistic demands on his ex-girlfriend, avoiding responsibility for it. As writer Charlotte testifies, "It's harder to call out somebody for being a bad friend or being self-absorbed if they mask their intentions with a bunch of pseudoscientific lingo they learned on TikTok" [3]. Thus, therapy-speak can serve as a strategy employed by the powerful to retain their unjust privileges.

Third, a concern regarding therapy-speak is that it has the potential to work as a status signal. Since access to fundamental mental-health care remains a privilege because of economic but also social barriers [54], there are strong reasons to assume that those more competent in therapy-speak might also be those wealthy enough to afford mental-health care, or to have access to mental health literacy. This parallels the use of medical terminology, a linguistic trend called "medicalese", which carries certain prestige [55–57]. In this context, the use of therapy-speak might be perceived as a form to signal both virtue and wealth. Those using psychotherapy terms might aim to be perceived as both wealthy enough to access mental-health care services, and virtuous enough to take responsibility for their behavior, aiming at self-improvement and self-care. Consequently, privileged people using therapy-speak might seek to garner more epistemic power in their interactions by leveraging

the reasonable assumption that those using such linguistic practice have had access to mental health care services and are taking responsibility for their behavior.

Finally, an ethical concern associated with some uses of therapy-speak, which underlies other noted ethical concerns, is that it presumes an objective stance towards someone who is entitled to a moral or participant stance. This concern is expressed by many testimonies, such as the statement "I understand setting boundaries, sometimes, but I also hate treating other people like commodities" [3]. As Strawson [58] notes, when interacting with others, one can take either a participant or an objective stance. The participant stance entails recognizing others as persons, that is, as responsible and moral agents. Contrarily, the objective stand entails interacting with the other as an object of social policy, that is, as something that needs to be managed, handled or avoided. According to Strawson, people tend to take an objective stand in some circumstances, such as when interacting with children or people with some incapacitating mental disorder, presumably because these types of people are not typically held accountable for their behavior. Yet, one can also use it in other circumstances "as an aid to policy; or simply out of intellectual curiosity" [59, p. 10]. This is what happens in some uses of therapy-speak. While people using psychotherapy terms might aim to help others by recognizing them as responsible and moral agents, those using therapy-speak, by reducing the experience of their interlocutors to superficial and imprecise psychotherapy labels, might frame their interlocutors as objects of social policy to be managed, rather than as moral agents deserving recognition, and respect. This objective attitude has already been criticized as a default attitude to be taken towards people with psychotic experiences and thoughts. According to Jeppson [59], it is important to view others as intelligible beings, namely, as people whose reasons, beliefs and experiences one can grasp. Taking this attitude towards others is crucial, even in the face of psychotic experiences, not only because failure to do so shows disrespect, but also because it allows fostering relationships, enabling empathy, promoting psychotherapy goals and mental health well-being. In line with this argument, it becomes imperative to avoid the objective stand, particularly when interacting with close others, as it tends to be the case in therapy-speak.

How is therapy-speak weaponized?

In addition to addressing previously discussed epistemic and ethical general concerns, the literature on epistemic injustice and mental health provides valuable insights into how therapy-speak can be weaponized, serving as a tool to promote, perpetuate, and generate some forms of injustice. To that end, the next sections focus on the use of therapy-speak by people in positions of emotional and social power, such as abusive partners or bosses occupying particular privileged positions in the socio-normative structure. In this section, we develop further how therapy-speak can be weaponized, promoting and perpetuating forms of injustice. In what follows, we first outline the sources of epistemic power held by mental health providers, then we highlight how the weaponized use of therapy-speak exploits this epistemic power to

achieve its unjust aims, and finally we illustrate how this dynamic might come into play in certain cases.

The epistemic power of mental health providers

The first point to note is that mental health providers hold a certain amount of epistemic power that comes mainly from their being an authority in certain realms of knowledge, but also from their institutional role. In essence, epistemic power is the capacity to influence what others believe and know [30, 60, 61]. For instance, a teacher has this power in relation to their students [60]. Critically, teachers have epistemic power because they are epistemic authorities in the fields in which they teach, but also because of their institutional role in the teacher-student relationship. Similarly, as we argue in what follows, mental health providers have epistemic power because of their expertise, but also because of their institutional position.

An important source of mental health providers' epistemic power comes from their expertise. As experts with detailed knowledge about mental health-related issues, mental health providers have the capacity to influence what people believe on such matters. In other words, a source of their epistemic power is their being epistemic authorities. An epistemic authority is someone who acts in a conscientious and proficient manner in seeking the truth [63, p.109]. As Archer et al. [62] highlight, epistemic authority and epistemic power are not to be conflated. While epistemic authority is regarded as a praiseworthy attribute, epistemic power is intended to be value-neutral. Mental health providers possess epistemic power for different reasons, but the possession of this power does not mean that they should have it. Yet one justification for their epistemic power might be their epistemic authority.

Another source of mental health providers' epistemic power comes from their institutional position. Because of their institutional position, they have the epistemic power to influence what is considered legitimate knowledge, and to determine who is allowed to exert epistemic influence in the diagnosis and treatment of mental disorders. For instance, the preference within the healthcare system for "hard" or objective evidence over patients' reports, despite its limited applicability in mental health, contributes to the epistemic asymmetries between mental health providers and service users [49, 52]. This preference grants epistemic power to the mental health providers, allowing them to determine the validity and relevance of first-person perspectives. Yet, as Scrutton [52] proposes, epistemic power could be constructed in a more collaborative way within the institution of healthcare by integrating the expertise of mental health providers with the lived experiences of mental health service users.

The strategies to weaponize therapy-speak

The epistemic power possessed by mental health providers unfolds across various practices, especially those taking place in mental health contexts. The specific vocabulary used by these experts is embedded with the relevant features of the practices in which they are usually employed [63]. In these practices, the experts'

epistemic power plays a significant role fixing the meaning of such terms. In this sense, the use of therapy-speak invokes mental health providers' epistemic power. Terms like 'trauma', 'narcissist' and 'OCD' carry the epistemic power typically held by those who use them in the professional context. This epistemic power plays a pivotal role in the mechanism exploited by the weaponization of therapy-speak, which relies on three main ingredients or steps: the appeal to a certain *epistemic authority*, the confusion of *descriptive and evaluative uses of language*, and the linguistic strategy of *deniability*.

The first strategy of those weaponizing therapy-speak is to invoke the epistemic authority of mental health providers to gain epistemic power. They aim at this by emulating the communicative style and the medical jargon commonly used by mental health providers. Mental health providers use medical language when describing mental health conditions, which often involves the use of specialized terminology or 'medicalese'. Research has shown that the use of specialized medical language can impact how individuals perceive the severity, representativeness, and prevalence of their condition [55–57, 64]. Similar to the influence of medical language in the context of physical health, the use of specialized terminology in mental health diagnoses, and the communication style of mental health providers, might influence how individuals perceive the severity, representativeness, and prevalence of their condition. In particular, the excessive use of medical jargon by mental health providers might lead patients to perceive them as more credible. In some cases, this can result in credibility excesses—where an unjustified high level of credibility is given to someone based on an identity prejudice– which can constitute a form of epistemic injustice [24, 65]. Consequently, a first strategy used by those weaponizing therapy-speak consists in exploiting the epistemic authority of mental health providers by taking advantage of the credibility excesses associated with the use of a psychotherapy communication style and medical jargon. The person aiming at gaining epistemic power would be either appealing to the epistemic authority of someone else, or merely pretending to hold such epistemic authority.

The second strategy used to weaponize therapy-speak consists in hiding evaluative claims under the guise of descriptive claims. For instance, in the case of 'psychwashing,' an abusive boss might tell their stressed, and overloaded employee, "You struggle with managing your workload because you lack time management skills". In this case, the abusive boss is shifting the blame onto the employee by presenting an evaluative claim as if it were a descriptive one. Yet the factual and normative realms, though mutually dependent, are fundamentally distinct [7, 66]. There are at least four main differences illustrating the descriptive/normative distinction in the literature: the type of information conveyed [66], the kind of disagreement they can give rise to [67], the way in which retraction works [68], and their connection to action [71, p.44]. As a way of example, consider this conversation between two security workers.

A: Let's record the arrival times. When did this guy arrive?

B: (1) This guy arrived at 5 PM. (2) He is a horrible person by the way.

In this toy example, (1) would count as a description, while (2) is an evaluation. Consider now some differences between them. (2) speaks a lot about B's mind, i.e., their worldview and values, while (1) says nothing particularly relevant of B's

values. (1) could be a fact, while (2) is closer to be an opinion. If A and B enter into a disagreement about (1), they will agree from the very beginning on how the dispute could be settled (e.g., "let's check the camera's record"), while if they disagree over (2), then they could also disagree over the relevant criterion to determine whether someone is a horrible person or not. If B realizes that (1) is false, they can retract it easily. However, (2) resists a bit more of a successful retraction: B could not fully undo the impact that (2) had in the conversation. Moreover, there are many more courses of action that can be expected from B after uttering (2) than after uttering (1).

Despite these differences, it is difficult to distinguish between descriptive or evaluative speech at first sight [69], partly because sentences stating facts and expressing opinions are structurally similar, even identical sometimes.[13] Such is the case of the abusive boss' statement about an employee's lack of time management skills that we previously mentioned, allowing the company to shape the conversation so that the focus is on the employee's skills rather than the company's practices—which in turn limits the range of responses available to employees and prevents discussion of the company's unfair practices [72, 73].

Thus, the underlying strategy consists in invoking or making salient the epistemic authority of certain experts through the use of therapy-speak to generate the impression that what is being said belongs to the realm of facts, when in reality it also involves evaluations. As an epistemic authority, a speaker can have the final say on a certain issue by presenting facts rather than opinions, as their epistemic authority gives weight, and credibility, to their statements. Thus, making salient certain epistemic authority in a specific field of knowledge to support a certain normative stance can function as a form of manipulation.[14] Jason Stanley calls *undermining propaganda* to a similar manipulative strategy [77, p. 40].[15]

Finally, the exploitation of mental health providers' epistemic authority and the conflation of descriptive and normative terms allows for a third strategy to weaponize therapy-speak: the linguistic strategy of deniability. Speakers employing the previously highlighted strategies retain "plausible deniability" [75, 76], i.e., they can insist that their words have been misunderstood, because they were talking about facts, not opinions, and then try to avoid accountability for what they actually did.

The mechanism we are trying to expose works as follows: the perpetrator illegitimately invokes the epistemic authority of mental health providers to gain epistemic power. They invoke such epistemic authority by appealing to evidence and using concepts of such experts' area of expertise—i.e., therapy-speak– to covertly urge their victim to emotionally manage an unjust and harmful situation in a very particular way that perpetuates the very injustice. In all these cases, certain evidence and facts are appealed to, exploiting the status that comes with the relevant epistemic authority, to camouflage an issue that is not factual, thus favoring a particular

[13] There are many different contextual factors involved in the meaning determination process [70, 71], including the speaker's epistemic authority (e.g., being a psychologist).

[14] Situations exhibiting this manipulative strategy of disguising in a purely factual appearance an evaluative use of language have been recently analyzed [see 74, p. 410-414].

[15] See also Quaranto and Stanley [74], and Beaver and Stanley [63].

perspective on that issue and leaving little room for rebuttal.[16] If accused, perpetrators can defend themselves by claiming they are just pointing to evidence, facts, and data, not ideology. That is, if they are caught, they can still deny that the act they have really performed with their words is the act of which they are accused. This is so because they mask a highly value-laden position and present it as value-free to distort the discussion and gain an advantage. As a result, victims are, in some way, compelled to handle the episode of injustice they undergo in a specific manner that silences them and perpetuates the injustice they are actually experiencing.

Thus, the weaponized use of therapy-speak to maintain and promote certain unjust situations exploits the epistemic power conferred on mental health providers, presents a non-factual issue as if it were a matter of facts on which certain evidence has the last word, and retains the linguistic strategy of deniability, which is the possibility of denying, in risky situations, that one has said what one has in fact claimed.

Cases where therapy-speak is weaponized

Now that we have explained which strategies might be used in the weaponization of therapy-speak, we illustrate how those come into play in the real-life and unjust situations that we previously introduced.

Consider once again the case of Jonah Hill. His use of the expression "these are my boundaries for romantic partnership", as mentioned, serves the function of somehow attempting to impose abusive and sexist conditions without appearing as such. Hill presents these demands not as a misogynistic attempt at control, but simply as personal boundaries, the kind psychologists advise us to set for a better life avoiding harm. Brady has little room for replying. It seems she can only accept or reject such conditions, in part because Hill's claim is framed in a way that conveys the impression that it is a reasonable invitation, a matter that truly belongs to the boundaries of individual preference, when in reality it constitutes an attempt at gender-based control and manipulation. In this case, therapy-speak is used to manipulate another person, presenting oneself as an epistemic authority on the matter, and a clearly value-laden issue as if there are no possible opinions on it. Hill's claim somehow tries to force Brady to handle the situation in a very specific way, leaving little room for the victim to articulate the deeper injustice she is experiencing.

The case of 'psychwashing' is even clearer. Companies with unfair and harmful working conditions for many of their employees conceal and maintain these conditions, which benefit the company, using therapy-speak. Specifically, by inviting their employees to attend therapy sessions and learn how to set their own boundaries,

[16] This mechanism can be explained in various ways within the philosophy of language, and its details can be approached from different theories; in this paper, we remain silent regarding which theory is best suited to flesh it out. An analysis of the weaponized use of therapy-speak might be provided through the lens of speech act theory. While a comprehensive analysis is beyond the scope of this paper, a proposal would be that in therapy-speak, a perpetrator might use psychotherapy language not to convey information but to impose a certain emotional response on the victim. This parallels the argument that hate speech, such as an utterance of "whites only" in a restaurant, enacts permissibility facts by prescribing who is permitted or excluded [77]. Similarly, therapy-speak might exert a coercive influence through its communicative intent. We are indebted to Alfred Archer for this suggestion.

they employ typical concepts from psychotherapy to somehow compel their workers, victims of unfair conditions, to manage such situations in a way that actually preserves these conditions and perpetuates the injustice. These companies disguise a situation of, for example, workplace harassment and exploitation, as one where the employee needs to learn to set their own boundaries and handle stress better, and they do so by appealing to the authority of experts through the use of therapy-speak. This way, the real problem is hidden under a distorted narrative presented with the power conferred by therapy-speak. If accused, they can deny it: they can still argue that they were just taking care of their employees' mental health, offering advice and support rooted in clinical evidence.

Note that this strategy, at least in the cases discussed above, is employed by people occupying powerful and privileged positions, with the goal of keeping their unjust privileges. That is, therapy-speak, at least in these cases, becomes a weapon to perpetuate oppressive relationships. That is part of the reason why unmasking the weaponization of therapy-speak is relevant: it is another covert strategy increasingly employed to perpetuate oppressive and harmful practices.

Affective injustice

In the previous section, we discussed how the weaponized applications of therapy-speak rely on the epistemic power of health professionals, on the conflation between descriptive and normative claims, and on the linguistic strategy of deniability. The aim of such weaponization of therapy-speak is to unjustly impose a specific way of managing challenging, and unjust, situations. According to some testimonies of therapy-speak, "it completely negates the other person's feelings" [3]. The failure to give uptake to the other person's emotional experiences, the demand for a certain way of emotion regulation, the imposition of a privileged group's emotional norms and the deterioration of a group's affective hermeneutical resources can be viewed as instances of affective injustice.

The concept "affective injustice" has been proposed to emphasize how social conditions, including norms, practices, and relationships, can exert oppression on people's affective states [78]. Within this framework, philosophers have identified different forms of injustices or wrongs that people might encounter in relation to their capacity as affective beings [79, 80]. Srinivasan [81] highlights the demand for oppressed groups to restrain their anger, Whitney [82] underscores the lack of uptake for their affective experiences, and Archer and Matheson [79] point to instances where privileged groups impose their norms of emotional expression onto others. In all these instances, affective injustice is said to emerge when those in positions of power actively suppress, block or dismiss the affective experiences of those who do not possess comparable power [83]. As a consequence, the term "affective injustice" brings attention to the social and emotional costs of injustice, expanding our understanding of injustice beyond its economic, or political harms [83].

Gallegos [84] draws on the broader philosophical literature on justice to note that justice prevails when individuals possess the goods they are owed, such as freedoms,

resources, opportunities, and forms of recognition. Injustice, in turn, is characterized as the morally objectionable deprivation of these goods. Gallegos extends this conceptual framework to the realm of affective justice, asserting that such justice exists when individuals have the affective goods they are owed for living desirable, excellent, or thriving emotional lives. Affective injustice, by contrast, is defined by Gallegos as the morally objectionable deprivation of such affective goods. Central to his argument is the identification of two core affective goods: subjective well-being, defined as the degree to which someone experiences positive affective states as opposed to negative ones and has a positive affective evaluation of oneself and one's life; and emotional aptness, which refers to how well one's emotional responses align or correspond with evaluative qualities in the world. Both core affective goods, according to Gallegos, are supported by a range of subsidiary affective goods, such as affective freedoms, affective resources and opportunities and affective recognition, which play crucial roles in establishing and maintaining the core affective goods of subjective well-being and emotional aptness.

On the other hand, defending a structural approach to affective injustice, Stockdale [78] identifies affective injustice with all those social conditions, including norms, practices, and relationships, which can exert oppression on people's affective states. Accordingly, what matters to identify whether certain practice or norm generates affective injustice is whether these endorse and perpetuate implicit affective norms that perpetuate oppression and discrimination. For instance, the demand for oppressed groups to restrain their anger would amount to affective injustice because it endorses an affective norm that hinders the capacity of the group to resist oppression.

Connecting the literature on affective injustice with our account of how therapy-speak is weaponized, we are now in a position to see how therapy-speak might generate affective injustice. In what follows, we argue that the use of therapy-speak might generate affective injustice because it risks failing to give uptake to others' emotional experiences, imposing both a specific form of emotion regulation and the emotional norms of the privileged group, and deteriorating a group's affective hermeneutical resources. Let us unpack these claims.

First, the use of therapy-speak risks failing to give uptake of the emotions of others. For instance, when the affective experiences of overworked and stressed employees are met with recommendations for the employees to seek professional help by mental health providers, this use of therapy-speak fails to fully empathize with the immediate concerns and emotions of the employees, partly because the psychotherapeutic terms used will be misguided. This response, even if well-intentioned in encouraging mental health support, overlooks their affective experiences and workplace challenges. When people resort to psychotherapy jargon, they might inadvertently create a communication barrier by relying on professional language that might not resonate with the lived experiences of those they are interacting with. This disconnect can be especially pronounced when the speaker employs clinical terms without fully acknowledging or validating the emotional nuances expressed by the other person. Furthermore, because the employees are reacting to an unjust situation, failure to give uptake to such

reactions perpetuates the injustice they are facing, and generates an additional form of injustice related to their affective experience.

This risk of therapy-speak to fail to give uptake of the emotions of others aligns with the idea of "affect-related testimonial injustice", which is defined as the silencing, smothering or lack of uptake given to someone's affective experiences [84]. Therefore, therapy-speak risks contributing to affect-related testimonial injustice by hindering genuine acknowledgment and understanding of people's emotional experiences in reaction to injustice, and by depriving individuals of the appropriate affective engagement they deserve. This, in turn, deprives those already facing unjust situations of affective recognition, as their emotional experiences are not respected, and of access to affective resources, as their emotional needs are not properly addressed.

Secondly, therapy-speak might work as an imposition of a certain form of emotion regulation. Back to the case of psychwashing, the recommendations to seek professional help given in response to the employers' negative experiences in a stressful work environment might convey the message that the appropriate way to regulate those emotions at work is to rely on external intervention, such as therapy, rather than addressing the root causes of the stressful work environment and advocating for systemic changes. When people use therapy-speak in everyday conversations, they might unconsciously signal an expectation for others to conform to a specific emotional management approach. This demand for emotional regulation can be perceived as an attempt to impose a particular coping mechanism or response, potentially disregarding the diverse ways individuals process and express their feelings, particularly in response to injustice.

This potential of therapy-speak to serve as an imposition of a certain form of emotion regulation aligns with Srinivasan's [81] understanding of affective injustice. Srinivasan defines affective injustice as "the injustice of having to negotiate between one's apt emotional response to the injustice of one's situation and one's desire to better one's situation" [85, p. 135]. This definition highlights the challenges people from oppressed groups face when their justified emotional reactions to oppression are deemed counterproductive. Focusing on anger, Srinivasan highlights how people from oppressed groups are put into the normative and psychological conflict of having to choose between their apt anger, or a more productive emotional expression. Building upon Srinivasan's work, Archer and Mills [80] emphasize the role of emotion regulation in this process. They draw attention to how all of the forms of emotion regulation that oppressed people might use to regulate their anger involve either ignoring the fact of their oppression, or a harmful form of emotion regulation. As a consequence, Archer and Mills reinterpret Srinivasan's cases of affective injustice as entailing not only a psychological and normative conflict, but also as a situation in which "they cannot deploy any of the standard emotion regulation strategies without further cost, either to the cause of challenging their oppression or to their own well-being" [84, p. 88].

In the case of therapy-speak, people in unjust situations are faced with a similar situation. They might be imposed a certain form of emotion regulation or certain forms of emotion expression to deal with their challenging, and unjust, situations, which might also make them either oversee their unjust situation or to deal with it in

a harmful way. This, in turn, deprives those already facing unjust situations of affective freedom, as they can neither avoid situations that cause them affective distress nor can they engage in emotional expressions that might challenge the expected norms regarding appropriate emotions in those situations.

Thirdly, therapy-speak might work as an imposition of certain emotional norms, or "feeling rules" [85]. When the overworked employer is advised to seek professional help to cope with their stress and frustration, they are not only expected to regulate their emotions in an individualistic way, but also to adopt the emotional practices of the privileged group. In corporate environments, especially those dominated by more privileged demographics—whether by gender, race, or socioeconomic status– the overworked employer might feel pressured to conform to the emotional style of the organization, which is likely to be dismissive of oppressive practices and injustices.

This potential of therapy-speak to impose certain emotional norms aligns with what Archer and Matheson [79] have called "emotional imperialism". According to them, emotional imperialism is a form of affective injustice that occurs when privileged groups impose their norms of emotional expression onto others. Their main case is the British practice of wearing a red poppy to commemorate the British Armed Forces. According to their analysis, which sees the practice of wearing the red poppy as an expression of admiration towards the British Armed Forces, pressuring people from diverse cultural and historical backgrounds, with complex relations to the British Army, constitutes a form of emotional imperialism because it consists in imposing the dominant culture's emotional norms on the less powerful group, and marking the other culture's emotional norms as inferior.

In the case of therapy-speak, people in unjust situations might also face emotional imperialism. Through the use of psychotherapy terms, they might feel pressured to conform to the emotional tone of the powerful and dominant group. A consequence of this form of affective injustice is that those in the oppressed group might be deprived of their legitimate affective resources to cope with unjust situations.

Finally, the use of therapy-speak risks deteriorating the already scarce affective hermeneutical resources available to those struggling with mental health.[17] For instance, when one uses 'depression' to refer to everyday sadness, or 'trauma' to refer to mild discomfort, one contributes to the appropriation and deterioration of affective hermeneutical resources that have been crucial for people with mental health challenges to understand and share their affective experiences.

This risk of therapy-speak to deteriorate affective hermeneutical resources aligns with the idea of "affect-related hermeneutical injustice", which occurs when a person or group's ability to interpret their own and others' affective experiences and emotional responses is unfairly constrained or undermined due to the historic exclusion of that group from the practices of curating and mainstreaming affective hermeneutical resources [84]. Therefore, therapy-speak risks contributing to affect-related hermeneutical injustice by depriving those struggling with mental health of the

[17] We are indebted to Sara Kok for this suggestion.

appropriate hermeneutical resources that they need, and deserve, to make sense of their emotions.[18]

In conclusion, the weaponized use of therapy-speak can not only promote and perpetuate injustice but also generate affective injustice by neglecting the emotional experiences of individuals, imposing a specific form of emotion regulation and a set of emotional norms, and constraining their ability to understand and share their emotional experiences.

Conclusion

In this paper, we have dealt with the emerging phenomenon of therapy-speak. In particular, we have addressed some of its epistemic and ethical concerns, and identified a weaponized use of it. First, we discussed some epistemic consequences related to three dangers that therapy-speak entails: it could erode the meaning and relevance of certain mental health terms, promote pathologizing practices, and encourage self-diagnosis. Second, we explored four ethical outcomes of therapy-speak: it can be used to discredit individuals, avoid accountability, signal social status, and take an objective stance. After, we discussed in detail a mechanism underlying the weaponized use of therapy-speak. This mechanism involves three key ingredients: the appeal to certain epistemic authority, the confusion between descriptive and evaluative uses of language, and the linguistic strategy of deniability. Finally, we argued that the weaponized use of therapy-speak can generate forms of affective injustice, because it forces the victim to emotionally manage an unjust situation in a way that perpetuates the very injustice suffered.

As far as we know, this paper is the first one to provide a philosophical analysis of therapy-speak. Consequently, it opens the door to many further lines of research. First, in our analysis, we have not distinguished between first and third person perspectives in the use of therapy-speak. Distinguishing the impact of therapy-speak when used to account for one's behavior compared to when used to account for someone else's behavior might uncover different implications. Secondly, in our analysis we have focused on the non-ironic use of therapy-speak. Yet therapy-speak is sometimes used ironically, or metaphorically. For instance, someone might ironically say that they have OCD because they need to keep their desk tidy, without really meaning to self-diagnose themselves. An exploration of the ironic versus non-ironic use of therapy-speak might also uncover different epistemic and ethical concerns. Finally, empirical studies could be conducted to test the empirical predictions that follow from our proposal. For instance, it could be tested whether

[18] A similar connection between affective injustice and mental health language has been proposed by Lavallee & Gagné-Julien [41]. They argue that the pathologization of everyday emotions causes affect-related hermeneutical injustice to those struggling with mental health problems because it reinforces the monopolization of biomedical hermeneutical resources at the expense of alternative ones. Our paper's focus though is slightly different: we argue that therapy-speak (the inappropriate and superficial use of psychotherapy language) harms those struggling with mental health problems, not only because it pathologizes their emotions but also because it deprives them of these already scarce and monopolized hermeneutical resources through appropriation and deterioration.

vignettes depicting the use of therapy-speak to discredit individuals lead participants to form more negative judgments about the targeted individuals and more positive judgments about those using it, in comparison to vignettes where no psychotherapy terms are used. By gathering data on the impact of therapy-speak, one could refine the dangers that we have identified.

Acknowledgements This research was supported by a grant from Generalitat Valenciana (CIGE/2023/008), the research project (PID2023-150151NA-I00) funded by the Spanish Ministry of Science, Innovation and Universities, and a Grífols Research Grant in Bioethics of the Fundació Víctor Grífols i Lucas. We thank Alfred Archer and anonymous reviewers for comments on earlier drafts. We appreciate Gloria Andrada, Saray Ayala, Karen Arnold-Frost, José L. Guerrero, Quill Kukla, Pilar López-Cantero, Ana Muros, Kathleen Murphy-Hollies, Carmela Vieites and Neftalí Villanueva for insightful feedback. Versions of this paper were presented at the workshops "Agency and Knowledge in the Digital World" (Seville, 2024), "Authority and Metalinguistic Speech Acts" (Lisbon, 2024), "2º Prague-Valencia Workshop on Analytic Philosophy" (Valencia, 2024), "Understanding Ourselves through Others" (Birmingham, 2024), and at the Society for Applied Philosophy conference (Oxford, 2024), and the OZSW Conference (Eindhoven, 2024). Many thanks go to the assistants of such events for helpful discussion and feedback.

Funding Funding was provided by the Generalitat Valenciana (Grant No. CIGE/2023/008), Fundació Víctor Grífols i Lucas, Research Grant, Ministerio de Ciencia, Innovación y Universidades, (Grant no. PID2023-150151NA-I00).

Declarations

Conflict of interest The authors declare none.

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