Erkenntnis
https://doi.org/10.1007/s10670-022-00652-5

ORIGINAL RESEARCH

Experiences of Silence in Mood Disorders

Dan Degerman[1]

Received: 12 May 2022 / Accepted: 22 December 2022

Abstract
This article challenges the consensus that silences about mental disorders are there to be broken. While silence in mental disorders can be painful, even deadly, the consensus rests on an oversimplified understanding of silence. Drawing upon accounts from depression and bipolar memoirs, this article names and analyses some salient experiences of silence in mood disorders. It does so with two goals in mind. The first is to show that mood disorders may involve several different kinds of lived experiences of silence. This is important because even though silence is considered a promising objective symptom of depression, little has been written about lived experiences of silence in disorders that involve depression. The second is to argue against the fetishisation of breaking silence and the concomitant understandings of silence as an externally imposed and inherently negative phenomenon. This is important because some silences are not experienced as external and are even felt to be valuable, meaning that efforts to break them may be counterproductive.

1 Introduction

A few years ago, the UK television network ITV launched the mental health campaign ‘Britain Get Talking’. As the name implies, the campaign’s aim was to tackle the silence around mental disorder head-on. It was launched in a headline-catching fashion on the popular TV show Britain’s Got Talent. In the middle of an episode, instead of of cutting to ads, the show’s hosts, Ant and Dec, explained the importance of talking about mental health and, to facilitate this, the show itself would offer a minute’s silence. During this silence, backstage staff were shown holding signs with words that together spelled out: ‘Use our silence to talk to each other. Try it now. Britain get talking’. When the minute ended, the hosts said ‘See, it wasn’t that hard was it?’ and the audience erupted in applause. The launch was widely celebrated in the media, with one magazine declaring: ‘ITV’s "Britain get talking" boldly harnesses the silence around mental health in a clever campaign that is perfectly

✉ Dan Degerman
dan.degerman@bristol.ac.uk

[1] Department of Philosophy, University of Bristol, Bristol, UK

Published online: 12 January 2023

pitched'. The campaign, which is still running today, and the response it received, reflect a widespread assumption. This is the assumption that silences about mental disorder are there to be broken. Agreement on this claim appears to be virtually universal, judging from countless articles in news, charity, and academic media (e.g. Breaking Braddock, 2017; Depression, 2020; Hinshaw, 2008). There are good reasons for this. Some silence is rooted in mental health stigma. It may lead people to hide their suffering against their better judgement for fear of the social consequences of disclosure and delay seeking care (Corrigan, 2018).

Much recent philosophical literature has focused on helping to break this silence. Foucault's (2006) famous observation that psychiatry 'is a monologue by reason *about* madness' that came into being through the silencing of 'the madman' has served as a slogan for these efforts. The scholars involved have rightly highlighted the continued scarcity of mental health service user voices in healthcare research, policy, and practice (Cooper, 2017; Potter, 2019; Rose, 2017). Relatedly, others, inspired by Miranda Fricker's (2007) concept of epistemic injustice, have argued that certain structural features of mental healthcare silence individuals with mental disorder (Beuter, 2019; Crichton et al., 2016; Scrutton, 2017).[1] These features include stigmatising beliefs about mental disorder, such as that individuals with mental disorder are less trustworthy or have less agency (Jackson, 2017). Another silencing structural feature of the current state of mental healthcare is the poverty of interpretive resources available to people in mental distress (Ritunnano, 2022; see also Kidd & Carel, 2019). The psychiatric concepts that dominate these resources may not only lead to an overmedicalised and decontextualised understanding of distress (see LeBlanc & Kinsella, 2016), but worsen stigma, doctor-patient power imbalances, and other problems that make people feel they should stay quiet about their distress (Beuter, 2021; Culbertson, 2016; Spencer, 2021). This scholarship is sorely needed because silence in and around mental disorder can be painful, even deadly. Yet, much of this literature assumes that silence is inherently bad. That is an oversimplified assumption that may threaten the effectiveness of efforts to give people in distress a voice and even exacerbate their distress.

This article names and analyses some salient experiences of silence in mood disorders. It does so with two goals in mind. The first is to highlight that mood disorders involve different kinds of silences and that these may form an important part of people's understanding of their own distress. The second is to unsettle widespread assumptions that silences in mood disorders are usually the result of stigma and silencing, and that they are necessarily bad because they are socially disempowering or detrimental to wellbeing. Differently put, I want to challenge the fetishisation of breaking the silence of mental disorder.

I have chosen to focus on mood disorders in this paper, although exploring silences in other disorders would likely also be fruitful. One reason for this choice is that silence and depression are strongly connected in medical, social science, and popular literature. In the latest edition of the American Psychiatric Association's

[1] Epistemic injustice refers to injustices committed against individuals in their capacity as knowers (Fricker, 2007).

Diagnostic and Statistical Manual of Mental Disorders (*DSM-5-TR)* (2022), silence can be found among the criteria for a major depressive episode, albeit within the broader concept of psychomotor retardation. Examples given of such retardation include, 'increased pauses before answering' and 'muteness'. In contrast to many other symptoms of depression which rely on patient testimony, such silences are considered an objective symptom (Peck, 2013). Some researchers even suggest that the silences of patients could form the basis for reliable computerised diagnoses of major depressive disorder (Cummins et al., 2015). Moreover, since Dana Jack's (1991) influential work on the matter, silencing has come to be widely considered a key cause of depression, particularly among women and other marginalised groups (e.g. Jack & Ali, 2010; Nolen-Hoeksema & Hilt, 2009). Finally, silence is a common topic among those who write about depression for general audiences, with many newspapers, charities, and healthcare providers warning of the many 'suffering in silence' from depression and 'the silent symptoms' of depression.

There is a second reason I am focusing on silence in mood disorders. Notwithstanding the concern with silence in depression within other fields, phenomenologists have paid little attention to experiences of silence in disorders that involve depression. That is particularly surprising given that towering figures of the tradition, including Heidegger (e.g. 2010: 159), Merleau-Ponty (e.g. 1964), and Sartre (e.g. 1947) all discussed the meaning and importance silence (see also Bindeman, 2017; Dauenhauer, 1980; Orange, 2020). Yet, in Matthew Ratcliffe's magisterial *Experiences of Depression* (2015), silence is not mentioned once.[2] He does discuss related phenomena, noting, for example, that many people with depression feel unable to describe their experiences (1–2). Ratcliffe also examines the felt narrowing of possibilities that such people report, particularly concerning their own ability to do things and be with others. This experience, he says, is characterised by a sense of 'I cannot do this' (61). Plausibly, many kinds of silence fall into this type of experience. Nevertheless, that still leaves much to be said about silence per se in depression. This paper is a contribution toward filling that gap.

I begin setting out the scope of my investigation by distinguishing between objective silence and three broad categories of lived experiences of silence: inner, outward, and outside silence. I then proceed to examine four types of silence that regularly appear in depression and bipolar memoirs—imposed, depressed, unknowing, and peaceful silence—highlighting how each complicates the imperative to break the silence around mental disorder. I conclude with some reflections on why we should pay more attention to these different silences, highlighting some avenues for further investigation.

[2] Neither does Ratcliffe (2015) discuss related experiences such as being unable to speak. The lack of concern for experiences of silence appears to be widespread in the phenomenology of mental illness and philosophy of psychiatry. For example, a search for 'silence' and 'silent' in *Philosophy, Psychology, & Psychiatry* yields only a handful of articles, which focus either on the silencing of people with mental disorder/distress or on silence as a tool of healthcare workers (e.g. Berthold, 2009; Kamens, 2020). Similarly, in *The Oxford Handbook of Phenomenological Psychopathology* (Stanghellini et al., 2019) any sustained discussion of silence considers only the silencing of people who experience mental disorder or distress (e.g. Jackson, 2019).

2 Objective and Lived Silences

The most intuitive definition of silence is probably 'the absence of any sound'.[3] Of course, sound is rarely, if ever, absent (van Elferen & Raeymaekers, 2015: 263). Depending on the instrument we use, we can find sound almost everywhere. So, perhaps what we ordinarily mean by silence is the absence of sound detectable by a normal human ear (see Jarowski, 1993: 159). In this sense, it can belong to a physical space or object—a room may be quiet—or one or more people—who are not speaking—or a combination of the two—a room may be quiet because people are not speaking. However, when describing people as silent, it may be necessary to broaden the concept to include the absence of some non-acoustic phenomena, such as non-verbal speech acts, as well. Someone who speaks sign language, for example, may intentionally and effectively communicate while being acoustically silent. The same goes for someone writing. Although it might be uncontroversial to say that an individual signing or writing to communicate is silent, when we talk about the silence of a person or people, we often mean that they are not communicating. Accordingly, someone communicating with sign language or writing is not silent, as there is no absence of communication (see Brito Vieira et al., 2019).

Intentional non-verbal communication could be bracketed as metaphorical silence (see Jarowski, 1993: 81), though doing so may have some confounding implications. For example, as I mentioned earlier, a person's silences may be taken as a symptom of a depressive episode. In such cases, researchers or healthcare professionals are concerned with the absence of speech rather than sound. If someone bilingual in English and British Sign Language transitioned from the former to the latter in a diagnostic interview, they would presumably not register to an observer as being silent in the diagnostically relevant sense. By contrast, someone with a slow and thoughtful speaking style might well register to an observer as being silent in the diagnostically relevant sense even though the speaker might not feel silent.

These definitional difficulties pertain primarily to silence in the objective or third-person sense. They relate to the question of whose and what behaviour counts as silence. How this question is answered may be practically important, for example, in clinical settings. It may also be politically crucial (Brito Vieira et al., 2019). It is noteworthy, however, that objective silence may not correlate to a lived experience of silence. As I just noted, some speaking styles may register for an observer as being filled with silences that have no salience to the speaker unless pointed out. Similarly, what an observer might experience as a person's meaningful silence, that person might experience as mindful preoccupation with a task.

In this paper, I am interested in lived experiences of silence. These may include but are not limited to acoustic phenomena and communicative acts. More specifically, I am concerned with the individual's experiences of their own silence rather than their experiences of other people's silence. Other people's silences are a salient experience among individuals with depression. For example, people with depression

[3] This quote is from https://www.dictionary.com/browse/silence/. But similar definitions can be found in other commonly used dictionaries.

often note that those around them do not seem to know what to say or avoid the topic of depression (e.g. Karp, 2017: 211). Other people's unwillingness to speak about depression, bipolar disorder, and other mental disorders are closely related to issues like stigma and epistemic injustice. In this paper, such silences will occasionally come into view in the form of what I call outside silence. Outside silence is the lived correlate of objective silence; it is an experience of the silence of other people, beings, objects, or spaces. However, while the silences of others can be related to the silences of the individual, one does not entail the other, and it is possible and important to distinguish between the two.

To narrow it down further, I am primarily concerned with experiences that involve outward silences, though these sometimes also involve inner silences. By outward silence, I mean the individual's silences toward or among other people, which usually involve not speaking. The word 'outward' here is meant to denote the individual's own silence, while 'outside' denotes the silence they experience around them. While the two are phenomenologically distinguishable, they sometimes blend into one another. An awkward silence, for example, can only arise between two people if they are both silent; differently put, from the point of view of the person experiencing the awkward silence, it consists of both outward and outside silence. Since experiences of awkward silence seem to entail an evaluation of awkwardness, they probably do not usually involve inner silence. By inner silence, I mean an individual's silence toward herself, such as the absence of some or all conscious thought. It is, in effect, the opposite of what is sometimes called inner speech (see Ihde, 2007).

As we shall see, unpleasant inner silence appears to be a common feature of depression. For example, Andrew Solomon (2015: 50) says becoming depressed 'is like going deaf, hearing less and less until a terrible silence is all around you until you cannot make any sound of your own to penetrate the quiet'. Jacobs et al. (2014: 107) say this quote illustrates a 'persecutory atmosphere of unbearable silence' reported by many people with depression. Since this concept of atmosphere is meant to underline the continuity between self and world, Jacobs and colleagues would perhaps object to my distinction between outward and inner silences. I do not mean to suggest that they are not related; of course, they are. Inner silence is likely to result in outward silence. If I have nothing on my mind when I am with others, I probably will not say anything. However, it is not necessarily the case. We do not always break outward silence because we have something to say, in the sense of having a preconceived thought that we want to share. Sometimes, we are dragged out of an inner/outward silence by someone's question or provocation. This ends our outward silence, but it may leave our inner silence untouched if the conversation is sufficiently easy. Heidegger's (2010) critical reflections on 'idle talk' help to illustrate how inner and outward silences can come apart. He observes that when 'losing itself in the publicness and the idle talk of the "they," [Dasein] fails to hear its own Self in listening to the theyself' (261). Once the conversation ends, we may sink back into double-sided silence. Hornbacher (2008) describes an experience along these lines in her memoir *Madness: A bipolar life.* She recalls her outward silence temporarily being broken during a depressive episode: "I find myself standing in front of a classroom with chalk in my hand. They will drop a nickel in me and I will begin to talk" (46). Like an automaton that can be activated by pressing the right button, so

Hornbacher could be made to speak, but it did not change the emptiness inside of her. Her inner silence remained untouched even though her outward silence was broken. The two silences can, thus, come apart.[4]

In everyday life, inner, outward, and outside silences are often entangled. But for the purposes of this paper, it is important to distinguish between them. The types of silences I discuss in the next section all involve outward silences. Some involve a combination of them; imposed silences can involve outside silence while depressed silence can involve inner silence. Thus, keeping in mind the three basic lived silences that I have described above will help us elucidate the structure of and differences between the more specific silences associated with mood disorders.

3 Silence in Memoirs of Mood Disorders

This section considers four silences that recur in memoirs of mood disorders. These are imposed silence, depressed silence, unknowing silence, and peaceful silence. Except for depressed silence—which involves a feeling that words have become absent—there is no reason to think these experiences are exclusive to mood disorders. Imposed silence, which is when someone feels they cannot say something they want to because of external factors like stigma and prejudice, is likely a common experience, particularly among marginalised groups. Similarly, unknowing silences—in which an individual feels they cannot speak because they cannot find the right words—and peaceful silence—a pleasant absence of thoughts, voices, or noises—are likely something that most people experience at times.[5] Yet, these are salient experiences in the memoirs I discuss. Those memoirs also feature several other types of silence, which I list in the conclusion. The reason I have chosen to focus on the above four is that they, on the one hand, are related to the kind of illicit silences that concern those who want to break the silence around mental disorder, and, on the other, because they draw attention to negative, neutral, and positive potentials of silence.

3.1 Imposed Silence

Accounts of imposed silences are a staple within memoirs of mood disorders. By imposed silence, I mean experiences in which individual feels they cannot speak despite wanting to because of other people's prejudices about, lack of empathy for, and inability to understand the individual and her thoughts and feelings, or because of social norms prohibiting their expression (see Kenny, 2011: Ch. 6; also

[4] The more obvious example of when inner and outward silences come apart is of course when we experience a rich inner dialogue without speaking or feeling the urge to speak.

[5] Radden and Varga (2013) have questioned the epistemic value of memoirs of mental disorders given factors such as norms of the autopathography genre and the limits of human memory. However, others have offered convincing replies to these concerns (e.g. Hoffman & Hansen, 2017; Tekin & Outram, 2018).

cf. Spencer, 2021: 147). It involves an outward silence that is felt to be involuntary and unpleasant. It is also non-communicative; by this, I do not mean that someone observing the objective silence that arises from this experience of silence couldn't find some meaning in it. Rather, I mean that imposed silence is not intended to be communicative (see Tanesini, 2018).

People with depression and bipolar disorder sometimes describe imposed silences using metaphors of blockage, like 'brick wall' (Brampton, 2018: 103), 'barrier' (Solomon, 2015: 364), and 'darkness' (Karp, 2017: 138; see also van Elferen & Raeymaekers, 2015: 263), or metaphors of isolation, like 'well of silence' (Karp, 2017: 3), referring to something that is preventing them from voicing their distress to others. David Karp and Andrew Solomon, in their respective books on depression, are struck by how many of the people they interviewed felt like they could not speak to anyone about their depression, often because of worries about being misunderstood or judged negatively. The following extract from an interview that Karp conducted with a female graduate student named as Karen is representative:

> Karen: "No one in my life right now knows … I'm so eager to talk to you about [my depression] because I can't talk about it with people."
> Karp: "It must be hurtful not to be able to talk about so critical a part of your biography."
> Karen: "Yes, but I don't want to test it with people. … [If I told them] they might not say anything, but their perception of me would change."
> (Karp, 2017: 126)

All the features I mentioned in the definition of imposed silence above are present here: the involuntariness—Karen clearly wants to talk her feelings but feels she cannot because of what other people think; the unpleasantness—it is 'hurtful; and the non-communicativeness—by not speaking about it she hopes people will not be able to tell she has a mental disorder. And all this results in her being outwardly silent. Also notice the relief that Karen expresses in feeling able to break this silence, even for a moment with a stranger.

Imposed silences are, plausibly, often a result of *silencing practices* grounded in mental health stigma. Elsewhere, for example, Karen says that her reticence is directly related to her fear of what the consequences would be of others seeing her as someone diagnosed with depression who has received treatment in an inpatient facility, that is, as she puts it, 'a depressive' and 'a mental patient'. Similarly, Mary Cregan identifies her previous silence about her depression with a culture of 'self-suppression' particularly within her family but also in society more broadly. This led her to reason: "My trouble was invisible, and I sensed that I should keep it that way'. Because of mental health stigma, people like Karen and Cregan may rightly judge that others cannot be trusted to understand what they have to say about their distress and, so, that speaking simply is not worth the risk; it is better to remain silent. This corresponds to a type of silencing practice that Kirstie Dotson (2011) has called testimonial smothering, which is when an individual truncates their testimony to avoid unwelcome friction from their audience.

Testimonial smothering usefully captures how mental health stigma may fuel silencing practices that lead to experiences of imposed silence. It may seem

obvious that silencing implies that someone or something is made to be silent. But in the philosophical literature, silencing can refer to a range of practices and effects, many of which may involve neither objective nor lived experiences of silence. Usually, silencing refers to the failure of that intentional meaning to receive uptake from an audience. For example, a phenomenon like illocutionary silencing—which is what philosophers usually seem to have in mind when talking about silencing—necessarily involves a speaker actively and intentionally expressing meaning (Caponetto, 2020; see also: Tanesini, 2018). Indeed, part of what is so pernicious about instances of illocutionary silencing is that someone *is* speaking even though they might as well not be. In such a situation, it seems unlikely that either speaker or audience would experience the speaker as being silent. Testimonial smothering also does not necessarily involve lived silence. A person can truncate their testimony by withholding risky information from the audience while still saying something, in which case, they are 'silent about' something without experiencing themselves as being silent. This is not silence in the sense I am concerned with here. I am concerned with instances in which individuals recognise that they are being silent. That does not mean silence in the sense of not speaking about something (silence about) or not being heard when speaking about something (illocutionary silencing) is irrelevant. An individual who regularly finds themselves in situations where ignorant or prejudicial audiences force them into communicative contortions may eventually decide that it is better to just stay silent. Likely, this is the origin story of many imposed silences.

Given their connection to mental health stigma and silencing practices, imposed silences seem to be precisely the sort of silence that campaigns like 'Get Britain Talking' should target and might be effective in addressing. Someone, like Karen or Cregan, who has long been suffering from depression in silence silent may well appreciate the conversational space created by the launch, the implication that it is socially acceptable to open up about mental distress, and that it encourages other people to talk about mental health problems, effectively breaking the outside silence about such problems. Consequently, the individual might feel able to break their imposed silence, speak about their distress, and find support from those around them.

Many authors see themselves as part of this effort. Memoirists from Styron (2004) and Solomon (2015) to Brampton (2018) and Marchenko (2016), have framed breaking the silence around mood disorders as a key objective, often with the implication that everyone, depressed or not, ought to work toward this goal. Some, like Brampton, go a step further, implying that silence as is inherently bad, maybe even unhealthy, and seeking to break that silence by speaking is inherently good, perhaps even healthy. And a similar sentiment seems to be reflected in the indiscriminate assault on silence by campaign's like Get Britain Talking.

Yet, not all silences are imposed. Some are involuntary and unpleasant but not imposed. Others are voluntary and pleasant. Moreover, imposed silences can also blend with other types of silences in complex ways (see also Clair, 2013). We find an illustration of this elsewhere in Brampton's memoir:

> When I was very ill, I became so tired of people telling me that things would get better. I felt, always, that I must try to comfort them by agreeing. Either that, or stay silent. There were no words to explain the depths of my despair. I didn't understand it myself. (Brampton, 2018: 18)

This seems like an instance of testimonial smothering and, potentially, imposed silence. The pressure of other people's expectations, specifically the expectation that she is in recovery, impose on Brampton a choice between distorting her experiences for public consumption or remaining silent. Yet, her words also suggest there may have been more behind her silence, such as a suffering that makes it difficult to speak and an absence of words that might render that suffering intelligible. This corresponds to the two kinds of silence I will consider next: depressed silence and unknowing silence.

3.2 Depressed Silence

Silence can be experienced as an aspect of depression. As discussed earlier, some mental health researchers and practitioners consider the silences of a patient an objective symptom of depression. However, they have paid less attention to the lived experience of silence that may or may not accompany symptomatic silence (e.g. Cummins et al., 2015). Indeed, the *DSM* explicitly advises against interpreting 'subjective feelings' as evidence of psychomotor retardation. Yet, another criterion for a depressive episode picks out a kind of inner silence in the form of a '[d]iminished ability to think' (APA 2021: 184). We shall see that this corresponds to some of the experiences I describe below. This is noteworthy because it means that a person experiencing objective, outward, and inner silence, or what we might regard as a more complete silence, could be fulfilling two criteria for depression, a point I will return to in the conclusion.

Despite this, philosophers of psychiatry, mental health campaigners, and other activists have paid little attention to silences that may be constitutive of mood disorders, focusing instead, as noted, on imposed silences and how to break them. But what I propose to call depressed silence is described in many memoirs of mood disorders (e.g. Brampton, 2018; Ipki, 2019; Marchenko, 2016; Merkin, 2017; Solomon, 2015). By this, I mean an experience defined by an unpleasant inner silence though it likely often involves outward silence as well. In contrast to imposed silence, subjects of depressed silence do not attribute this experience to something outside themselves and do not feel like they are unable to say anything. Instead, they feel like some change within them has deprived them of words, leaving them without anything to say.

Depressed silence does not reflect what many scholars have called the ineffability of depression, which refers to the inability to describe the distress and feeling involved in depression. Ineffability suggests that the silent subject has something they would like to talk about but lacks the conceptual resources to express it. Although this experience relates to another important type of silence that I name 'unknowing silence' in the next section, it is distinguishable from depressed silence. In depressed silence, it is not that the right words cannot be found but that

no words can be found: the possibility of speaking has disappeared. This experience, which could plausibly be understood as a specific aspect of the felt narrowing of possibilities that Ratcliffe (2015) considers integral to depression, is palpable in Solomon's (2015: 51) recollection of a period of deep depression: 'I could not manage to say much; words, with which I have always been intimate, seemed suddenly very elaborate, difficult metaphors the use of which entailed much more energy than I could possibly muster'. Brampton (2018), a journalist, recalls wondering where her words had gone during a severe depressive episode: 'What was it I had to say? I can see myself [before depression], sitting at my computer, head bent, writing furiously, hands flying over the keys. [Now, in depression,] I can't imagine what must have been in my head to make my hands go so fast' (33).

Similarly, Gillian Marchenko (2016) describes finding it difficult to communicate with her husband, Sergei, during bouts of depression and how this difficulty correlates to the severity of her depression. Sometimes, this was related to not finding the right words (as in 'unknowing silence', discussed in §3.3), but, at other times, she says she 'I can't speak at all' (78). To try to manage this, Marchenko and her husband agreed to use a colour system to indicate the severity of her depression:

> Green means a good day. Yellow means I'm not well but trying, and red means, You are on your own with the family, I can't do anything. I can hardly speak.
> "How are you today?" Sergei asks.
> "Red."
> "How are you today?" he asks again.
> "Red."
> "How about today?"
> "I'm red, okay? Assume I am red unless I tell you otherwise," I snap. (78)

The colour system itself captures Marchenko's understanding of particular silences as a symptom of her depression. Moreover, the account of her interaction with her husband captures something else about silence in mood disorders. Trying to help someone with a mental disorder break silence, even with the best intentions and circumstances, can put undue pressure on them to speak when they feel speaking is impossible.

We can imagine similar situation playing out during the 'Get Britain Talking' launch. Say you are person experiencing depressed silence, and you are watching Britain's Got Talent with your family. The hosts announce a break in the show. But instead of cutting to adds, they turn to you. Silence is harmful, they say. It must be broken and everyone has a responsibility to help to do it. Now is the time to talk to your family members and we are giving you the space to do that, they declare, before falling silent. Your partner, who suspects you are suffering, turns toward you, smiles supportively, and says something about how they know things have been hard. You are gripped by a sudden panic, flailing for some kind of explanation, something that might divert attention and difficult questions. For what is there to say? Nothing. All you manage is a shrug. You can see the disappointment in your partners face before they turn away, and you wait for the silence on the TV to end.

Marchenko's account and the imagined scenario illustrate that the kinds of tactics involved in silence breaking efforts—such as consciousness raising, stigma reduction, and creating spaces for conversation—meant to remove social and conceptual obstacles to speech may be ineffective or even counterproductive for someone experiencing depressed silence. That is because their silence seems to be rooted in their distress itself rather than an external factor.

This has important implications, particularly for researchers and activists trying to address epistemic injustices related to mental disorder. One kind of epistemic injustice that has been identified in relation to mental disorder, in general, and depression, in particular, is *hermeneutical injustice*. This occurs when an individual lacks access to resources, especially concepts, that would enable her to make sense of her experience due to a maldistribution of such resources (Fricker, 2007: 148–149; 154–155). Regardless of whether they use the term hermeneutical injustice, mental health researchers often claim that individuals with depression are silent about their suffering because of hermeneutical injustice (e.g. Culbertson, 2016; Gordon, 2010). On such accounts, silences should be broken and the way to break them is by creating resources that will enable individuals with depression to speak. But what depressed silences suggest is that for some people in the grip of depression, such resources do not exist. What is missing for the person in depressed silence are not some words they never knew, which some well-meaning academic or activist might have endowed them with; it is the ability to use the words already known. Trying to break depressed silences, particularly by crushing them under the weight of new concepts and descriptions, hence, seems at least as likely to harm as to help.

Developing and deploying a more nuanced understanding of silence in mood disorders, one that recognises that not all silences are felt to be externally imposed, is therefore vital. Yet, as we have already seen, sometimes the problem is not that words *as such* are missing but that the *right* words are missing. *Prima facie,* this seems to be another instance in which epistemic justice approaches would be helpful. Next, we shall turn to a corresponding experience of silence.

3.3 Unknowing Silence

The ineffability of depression has received much attention in philosophical and popular literature on depression. Few scholars, however, have remarked on its connection to silence. That might be because ineffability does not necessarily entail silence. Someone who feels they cannot adequately express their feelings may try very hard to do so and speak profusely in the process. Along similar lines, someone might speak a lot about other things to draw attention away from their inability to express their distress. Yet, judging from accounts in memoirs of depression and bipolar disorder, the difficulty in articulating distress often does produce silence. More specifically, it produces what might be called 'unknowing silence'. The label signifies a silence that is felt to be related to one's inability to make sense of and express one's emotions, thoughts, or sensations. It may be unpleasant. Like imposed silence, unknowing silence may involve a sense of powerlessness and impossibility. Unlike imposed silence, unknowing silence is

primarily experienced as personal, though often redeemable, incapacity. However, as Froese (2020) observes, such experiences can also be pleasant if felt to provide the possibility to reflect on what does not yet know and increase understanding. This may involve a desire to explore the unknown or a motivation to think. That said, the pleasant type of unknowing silence may be rare in mood disorders.

When philosophers say there is something ineffable about depression, what they often have in mind is the difficulty, and perhaps impossibility, of expressing the emotions involved in depression to other people. Emotions are central to our self-understanding, not just because they might reflect our characters but also because they can motivate and sustain our actions. So, when we cannot express important emotions, like those involved in depression, this can give rise to a silence that extends far beyond those emotions. The following quote from Brampton's memoir illustrates this powerfully:

> The kitchen is huge and half finished, as if somebody has abandoned it in despair. They have. It was me. I decorated half of the flat and then I simply gave up. There are no units, just a few rudimentary cupboards; the fridge is ancient and most of the shelves in it have collapsed. The hot water tap is stuck fast. I haven't the energy to call a plumber. I'm not sure that I even know how. Sometimes this strikes me as odd. I used to head up a staff of forty and handle a budget of millions. Now, I can't even call a plumber so I wash up by boiling a kettle for hot water. I no longer think that's strange. I think it's normal. When they come to visit, I see the way my friends look at the kettle and then at me. *I don't know how to explain, so I say nothing*. (Brampton, 2018: 27; my emphasis)

Here, Brampton's inability to express her feelings seems to spill over into a more general reticence about her life. It seems likely that given the availability of better hermeneutical resources, Brampton would have been able to explain what was happening and, thus, speak.

Karen, whom we encountered earlier, also seemed to struggle with finding the right words, words that would have allowed her to speak and make others understand what she was going through. She said to Karp:

> I kept [my feelings of depression] quiet. … I might have talked about it with one of my friends, but no one understood. You can't talk about your depression with people who don't experience it. They don't understand. How are you going to bring it up? Everyone's so happy. You are going to start talking about this deep dark secret, deep dark hole (Karp, 2017: 112).

For some people, diagnoses and related tools and concepts, like medications, treatments, and aetiologies, constitute hermeneutical resources that equip them to understand and speak effectively about their distress with family, friends, or employers (Perkins et al., 2018: 755). This indicates that the types of mental health awareness campaigns pursued by anti-stigma organisations can be effective in breaking the unknowing silence of individuals with mental disorder. For

others, however, diagnoses exacerbate difficulties in breaking the silence of their distress partly because of the stigma attached to such labels (Perkins et al., 2018: 759). This may, as we have seen, add a layer of imposed silence. Some scholars and activists share the worry that psychiatric diagnoses undermines understanding of and fuels silences about mental distress, as does indeed the mainstream medications, treatments, and aetiologies of psychiatry, which are sometimes collectively labelled as the medical model of mental disorder (e.g. Culbertson, 2016; Gordon, 2010; LeBlanc & Kinsella, 2016). Many of them argue that we need to look beyond dominant hermeneutical resources to address the silence of mental disorder, by inventing, recovering forgotten, or highlighting underappreciated ways of making sense of the mental distress associated with mental disorder. But despite opposing certain aspects of current psychiatry and mental healthcare policy and activism, they agree on two key points: (1) the silence of those who have been diagnosed with a mental disorder needs to be broken; (2) achieving this means intervening on the hermeneutical resources related to those disorders.

By increasing the range of meanings that people with mood disorders can find and express in their distress, efforts of this kind may well be effective addressing some of unknowing silences that such people experience. But those of us who pursue such projects must still be careful. One reason for this is that, as we have seen, silences are not necessarily rooted in hermeneutical injustice. Unknowing silences can be closely related to imposed silence. As Karen's reflections above suggest, some silences may be simultaneously constituted by the feeling that the right words are absent and the sense that others simply would not understand. This might raise the worry that unknowing silences are really just imposed silences whose social roots have not yet been properly understood. However, other unknowing silences may instead overlap with depressed silences. For example, this seems to be what Marchenko (2016: 77) suggests when she says: 'I don't know what to say, and sometimes I can't speak at all' (see also Solomon, 2015: 51). As we have seen, in such cases, proffering new interpretive resources is not necessarily helpful.

There is a second reason we must take care when trying to break even unknowing silences. The fact that someone feels that there are no words to express their experiences does not mean they want such words even if they can be found. David Karp says that a key reason that the respondents in his book 'kept quiet' about their depression was because of what they 'perceived to be the inherent incommunicability of their internal experience'. This could be a misperception. These people could probably under the right circumstances—for example under conditions of hermeneutical justice—express more about their experiences than seems possible to them now. However, certain aspects of our lived experiences do seem to be inherently incommunicable or of a kind that we do not want to reduce to language. Words can represent our experiences, but they are obviously not equivalent to them. Numerous authors and thinkers, including phenomenologically inspired ones like Hannah Arendt (1998: 50–51), have observed that the more intense an experience, the more difficult it may be to put into words (for discussions, see van Hooft, 2003; Ritunnano, 2022). This seems plausible, though it neglects a related point that must also be considered. An outward silence accompanying a powerful emotional experience may partly be intended to communicate the depth of that experience, that words are

incapable of conveying it, and that trying to speak them would simply distort it (see Jarowski, 1993: 38; Kenny, 2011: 24). Well-intentioned efforts to break the silence around depression and bipolar disorder risk not just demanding the impossible of some individuals with those illnesses but also obscure meanings that their silence might be intended to convey.

In other words, although some unknowing silences are ideal targets for epistemic justice and anti-stigma campaigns that seek to educate people about and equip them with new concepts for articulating their experiences, other unknowing silences should not and perhaps cannot be broken.

3.4 Peaceful Silence

The silences I have discussed challenge oversimplified understandings of silence in mental disorder, which are seemingly assumed in many efforts to break the silence around mood disorders. We have seen that some silences may be constitutive of depression or the result of the inherent inadequacy of speech in expressing some facets of the powerful emotions that are involved in mood disorders. Since such silences may be experienced as unbreakable by their subject, efforts to break them might be, at best, futile and, at worst, harmful because they risk pressuring individuals with mood disorders to do something that seems and, in fact, might be impossible for them.

Imposed, depressed, and many unknowing silences have in common that they are unpleasant and involuntary. Even an unknowing silence intended to convey the inadequacy of words seems like an experience that, all things equal, we would rather avoid. Trying to break those silences might be the wrong approach, but other types of support and care might still be desirable to reduce their frequency or eliminate them. Before concluding the paper, I want to highlight a fourth type of silence that individuals with mood disorders seem to experience as both pleasant and beneficial. This is an experience that most of us will recognise, namely, peaceful silence. However, there are reasons to think that this experience assumes a different character for individuals with bipolar disorder and depression.

In the *DSM*, a key difference between bipolar I and II is that to be diagnosed with the latter a person must have experienced both a manic or hypomanic episode and a depressive episode, though bipolar I may also involve a depressive episode. The symptoms of manic and hypomanic episodes both include feeling the urge to speak and having difficulty stopping, as well as a ceaseless stream of racing thoughts (APA 2022: 140–145, 150–155). One might say that mania may involve an inability to find outward and inner silence. Neither symptom is necessarily unpleasant. The stream of thoughts, for example, can be welcome and pleasant. After all, it may constitute a break from depression and be accompanied by feelings of confidence (see Conibear, 2021). Yet, they can also be intrusive and painful. Bassey Ipki powerfully relates the latter aspect of mania in her book *I'm Telling the Truth, But I'm Lying* (2019). In the following extract, she is describing a cab journey from the airport to her apartment:

> The thoughts have started to flood. They tumble and race so quickly that only focusing on him [the cab driver, Hasaan] helps slow their circling. … *We drive*

> *from Queens to Brooklyn in silence, but my mind is never quiet*: yesterday, tomorrow, last night, tomorrow night, the next city, the last city, the next show, the last show, when will this end, need sleep, don't want food, don't want sleep, need food, sleep, sleep, sleep, sleep. I sigh and shake my head to clear the chatter. Hasaan looks at me through the rearview mirror. Smile. Invite him to talk. I need his voice as a solid rock against the dust crumbling around me. But I can't manage a smile and look away instead. (117; emphasis added)

These words express a yearning for peaceful silence, and it is noteworthy that hopes to find this silence in outward chatter, in idle talk, imagining that it could provide an oasis from the storm in her mind. In a way, her hopes seem to hinge on the potential for inner and outward silence to come apart.

What peaceful silence consists of is difficult to pin down. Inner silence seems to be an essential component of it. However, not all inner silences are peaceful. Depressed silence, for example, certainly is not, as Ipki herself indicates: 'Sadness returns quietly. Always quietly. No great trumpeting or horn blast. No drum circle or full-bodied gospel wail. No stunning metaphor or dazzling simile. There is only this throbbing and distant and empty and quiet' (245).[6] Hence, peaceful silence must also involve a component of pleasure.

Above, Ipki hopes that she might find such silence by breaking both her own outward and the driver's outside silence. At other times, outside silences seem to her essential to peaceful silence, as she seeks it out by escaping from the voices of other people or the noises of the city (38, 146). Yet, Ipki also explicitly contrasts peaceful silence with a kind of obtrusive silence she encountered in a hospital ward after being admitted during what seems to have been a severe mixed episode involving symptoms of both depression and mania. 'This silence is anything but peaceful. It sounds like the walls hold muffled screams', she writes. 'It creaks and groans and smells like the end of you' (102). In other words, while some outside silences may help constitute part of peaceful silence, just any outside silence will not do.

Outward silences can be an important part of peaceful silence. Keenly aware of how destructive mania-fuelled words can be to her relationships, Ipki often strains, sometimes unsuccessfully, to hold them back. She describes finding 'a way to focus on staying quiet and being still when it [the mania] became impossible to outrun' (87). Presumably, no strain is needed in peaceful silence, and outward silence comes with ease. Ipki suggests just how desperate the yearning for such silence can become in a wrenching account of overdosing on drugs at a party. As she was approaching what she thought was death, Ipki felt like 'the most beautiful and the most quiet and the most peaceful and the most steady and the most joy-filled person in the room' (91; see also Hornbacher, 2008: 33). These words gesture at a tragic longing to not be the person relentlessly talking, floating around the room from conversation to conversation.

[6] Some people with depression also report what appears to be peaceful silence after intrusive thoughts and emotions (e.g. Cregan, 2020: 219). Plausibly, peaceful silences may be pursued by people with other types of disorders as well (see Osler, 2021).

While the phenomenological slipperiness of peaceful silence makes it difficult to define, however, this very slipperiness is a reason to approach it with care where we suspect its presence. For although we might not be able to exhaustively describe peaceful silence, people seem to know when they are experiencing it. Often, they might be able to tell us that this is the case and so divert efforts to break their silence. But sometimes they may be unable to do so. Peaceful silences may be fragile, and the act of speaking might itself break them. But it could also be that an individual with bipolar does not know how to express the value of their peaceful silence, particularly when faced with pressures to speak and the implication that it is bad for people with mental disorder to be silent.

Peaceful silence then constitutes another complicating factor in efforts to break the silence of mental disorder. But it is also more than that. As an example of a beneficial silence, peaceful silence suggests that we should sometimes seek to preserve and facilitate silence. It is difficult to say what this means from a clinical perspective. After all, people are sometimes wrong about what is good for them, and they may be wrong about the value of peaceful silence too. Peaceful silence can, conceivably, be worse than a disturbing conversation if the former ultimately leads to more suffering while the latter would resolve it. Nevertheless, simply ignoring the potential desirability of silence for some people with bipolar disorder—and perhaps individuals with major depressive disorder as well—does not seem an acceptable option. This is especially true given the growing consensus that meaningful recovery must draw on the distressed person's own understanding of what that would involve (Price-Robertson et al., 2017).

4 Conclusion

This paper had two aims. The first was to show that mood disorders may involve several different kinds of lived experiences of silence. This is important because even though silence is considered a promising objective symptom of depression, little has been written about the experience of silence in major depressive disorder and bipolar disorder. The second was to argue against the fetishisation of silence breaking and the concomitant understanding of silence as externally imposed and inherently negative phenomenon, which is widespread in mental health activism and philosophical scholarship on mental disorder. This is important because if there are some silences that are not experienced as external and are perhaps even felt to be valuable, efforts to break them may sometimes be counterproductive.

Working towards these aims, I explored four types of silence: imposed silence, depressed silence, unknowing silence, and peaceful silence. The first three are salient because they correspond most closely to what scholars and activists have in mind when they say we have to break the silence of mental disorder. While some silences, like imposed silence, seem amenable such efforts, others, like depressed silence, do not. Individuals who experience depressed silence may not see any possibility of speaking, regardless of how favourable the external conditions are. Campaigns to break the silences around depression may unintentionally put undue pressure to speak on such individuals, which could exacerbate their distress. The fourth kind,

peaceful silence, was meant to illustrate that some lived experiences of silence in mood disorders may be desirable and, hence, *should not* be broken.

Paying attention to these different silences and how various phenomenological characteristics combine or come apart within them may be also be clinically important. Recall, for example, that silence, in the senses I have discussed here, appears twice in the criteria for a major depression episode. First, there is the psychomotor retardation criterion, which describes objective and potentially outward silences, like muteness or extended pauses in speech. Second, there is the thought retardation criterion, a '[d]iminished ability to think', which may be experienced as an inner silence. Depressed silence seems to often involve an unpleasant combination of these two, meaning that someone who experiences depressed silence would likely fulfil two criteria of a depressive episode. Yet, this more fine-grained understanding of experiences of silence should also make us doubt the promise of psychomotor retardation as an objective criterion of depression. That is because in several of the silences I have explored above and mention in the table below the outward silence that could register as paucity of speech may be pleasant, voluntary, and communicative. So, considering lived experiences of silence is important both in determining whether someone's silence should count as a symptom of depression at all as well as how salient a symptom it is.

This paper is an initial attempt to begin to map out experiences of silence in mood disorders. In the memoirs I analysed for this paper, I came across several other types of silence that would be worth exploring further. In the table below, I list these along with some of their key features (Table 1). Further examination of these silences may help us to avoid the sorts of pitfalls of silence-breaking discussed above and to better understand how silences may sustain or help to alleviate suffering in mood disorders.

None of what I have said in this paper should be taken to suggest that experiences of silence of whatever type are not socially contingent. We should be mindful

Table 1 Silences in mood disorders

Type	Phenomenological characteristics			
	Inner/outward/outside	Pleasant/neutral/unpleasant	Voluntary	Communicative
Imposed	Outward and sometimes outside	Unpleasant	No	No
Depressed	Outward and often inner	Unpleasant	No	No
Unknowing	Outward	Unpleasant	No	Sometimes
Peaceful	Inner and sometimes outward and outside	Pleasant	Yes	No
Intimate	Outward and outside	Pleasant	Yes	Yes
Obtrusive	Outward and outside	Unpleasant	Varies	No
Defiant	Outward	Varies	Yes	Yes
Tactical	Outward	Varies	Yes	No
Protective	Outward	Varies	Yes	Sometimes
Healing	Inner and sometimes outward and outside	Pleasant	Yes	Sometimes

of and seek to understand the social roots of all these experiences, roots which can undoubtedly be found even when silences feel internal, as in the case of depressed silences. My aim in exploring these experiences is not to disconnect them from social problems and injustices. Rather it is to highlight that the connection between them is more complex than is generally recognised, and that efforts to address those problems and injustices must take this into account. Future work on silence should, thus, seek to clarify those connections. Nevertheless, we must stop speaking and acting as though all silences in mental disorder are bad silences forced upon individuals in distress by oppressive institutions, attitudes, and norms. Sometimes they are good and hard won by the individual. When they are, they are probably all the more fragile and unable to resist pressures to break them.

Acknowledgements I am very grateful for the feedback provided by Francesca Belazzi, Havi Carel, and the journal's two anonymous referees.

Funding Dan Degerman is funded by the Leverhulme Trust (ECF-2020-583).

Declarations

Conflict of interest I declare no conflicting interests.

References

American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR*), 5thed., text revision. Washington, DC: American Psychiatric Association.

Arendt, H. (1998). *The human condition*. Chicago: University Chicago Press.

Berthold, D. (2009). Talking cures: A Lacanian reading of Hegel and Kierkegaard on language and madness. *Philosophy, Psychiatry, & Psychology, 16*(4), 299–311.

Beuter, A. (2019). Epistemic injustice and psychiatric classification. *Philosophy of Science, 86*(5), 1064–1074.

Beuter, A. (2021). Diagnostic overshadowing in psychiatric–somatic comorbidity: A case for structural testimonial injustice. *Erkenntnis*. https://doi.org/10.1007/s10670-021-00396-8/

Bindeman, S. L. (2017). *Silence in philosophy, literature, and art*. Boston: Brill.

Braddock, K. (2017). *Man down: Why do so many suffer depression in silence?* The Guardian, 13 August. https://www.theguardian.com/society/2017/aug/13/why-do-men-suffer-depression-in-silence.

Brampton, S. (2018). *Shoot the damn dog* (2nd ed.). London: Bloomsbury.

Breaking Depression. (2020). Spread the word. Breaking Depression. https://www.breakingdepression.co.uk/.

Brito Vieira, M., Jung, T., Gray, S. W. D., & Rollo, T. (2019). The nature of silence and its democratic possibilities. *Contemporary Political Theory, 18*, 424–447.

Caponetto, L. (2020). A comprehensive definition of illocutionary silencing. *Topoi, 40*, 191–202.

Clair, R. (2013). Imposed Silence and the story of the Warramunga woman: Alternative interpretations and possibilities. In S. Malhotra & A. Carrillo Rowe (Eds.), *Silence, feminism, power* (pp. 85–94). New York: Palgrave.
Conibear, K. (2021). *Living at the speed of light*. London: Jessica Kingsley Publishers.
Cooper, R. (2017). Classification, rating scales, and promoting user-led research. In J. Poland & S. Tekin(Eds.), *Extraordinary Science and Psychiatry* (pp. 197–220). Cambridge: MIT Press.
Corrigan, P. W. (2018). *The stigma effect*. New York: Columbia University Press.
Cregan,. (2020). *The Scar*. New York: W. W. Norton & Company.
Crichton, P., Carel, H., & Kidd, I. J. (2016). Epistemic injustice in psychiatry. BJPsych. *Bulletin, 41*(2), 1–6.
Culbertson, C. (2016). The omnipotent word of the medical diagnosis and the silence of depression: An argument for Kristeva's therapeutic approach. *International Journal of Feminist Approaches to Bioethics, 9*(1), 1–26.
Cummins, N., Schererc, S., Krajewskide, J., Schniederde, S., Eppsab, J., & Quatierif, T. F. (2015). A review of depression and suicide risk assessment using speech analysis. *Speech Communication, 71*, 10–49.
Dauenhauer, B. P. (1980). *Silence*. Bloomington: Indiana University Press.
Dotson, K. (2011). Tracking epistemic violence, tracking practices of silencing. *Hypatia, 26*(2), 236–257.
Foucault, M. (2006). *History of madness*. London: Routledge.
Fricker, M. (2007). *Epistemic injustice*. Oxford: Oxford University Press.
Froese, K. (2020). Unknowing silence in the Daodejing and Merleau-Ponty. In D. Chai (Ed.), *Daoist encounters with phenomenology* (pp. 247–273). London: Bloomsbury.
Gordon, R. A. (2010). Drugs don't talk: Do medication and biological psychiatry contribute to silencing the self? In D. C. Jack & A. Ali (Eds.), *Silencing the self across cultures.* Oxford: Oxford University Press.
Heidegger, M. (2010). Being and time. In Stambaugh, J., trans. New York: State University of New York Press.
Hinshaw, S. P. (Ed.). (2008). *Breaking the Silence*. Oxford: Oxford University Press.
Hoffman, G. A., & Hansen, J. L. (2017). Prozac or prosaic diaries? The gendering of psychiatric disability in depression memoirs. *Philosophy, Psychiatry, & Psychology, 24*(4), 285–298.
Hornbacher, M. (2008). *Madness: A bipolar life*. New York: Houghton Mifflin Harcourt.
Ihde, D. (2007). *Listening and voice* (2nd ed.). New York: State University of New York Press.
Ipki, B. (2019). *I'm telling the truth, but I'm lying*. New York: Harper.
Jack, D. C. (1991). *Silencing the self*. Cambridge: Harvard University Press.
Jack, D. C., & Ali, A. (Eds.). (2010). *Silencing the self across cultures*. Oxford: Oxford University Press.
Jackson, J. (2017). Patronising depression: Epistemic injustice, stigmatising attitudes, and the need for empathy. *Journal of Social Philosophy, 48*(3), 359–376.
Jackson, J. (2019). Phenomenological psychopathology and america's social life-world. In G. Stanghellini, M. Broome, A. V. Fernandez, P. Fusar-Poli, A. Raballo, & R. Rosfort (Eds.), *The oxford handbook of phenomenological psychopathology* (pp. 987–1004). Oxford: Oxford University Press.
Jacobs, K., Stephan, A., Paskaleva-Yankova, A., & Wilutzky, W. (2014). Existential and atmospheric feelings in depressive comportment. *Philosophy, Psychiatry, & Psychology, 21*(2), 89–110.
Jarowski, A. (1993). *The power of silence*. London: SAGE.
Kamens, S. R. (2020). Postcolonialism and (anti)psychiatry: on hearing voices and ghostwriting. *Philosophy, Psychiatry, & Psychology, 27*(3), 253–265.
Karp, D. (2017). *Speaking of Sadness*. Oxford University Press.
Kenny, C. (2011). *The power of silence*. Karnac.
Kidd, I. J., & Carel, H. (2019). Healthcare practice, epistemic injustice, and naturalism. In B. R. Sherman & S. Goguen (Eds.), *Overcoming epistemic injustice* (pp. 153–168). London: Rowman and Littlefield.
LeBlanc, S., & Kinsella, E. A. (2016). Toward epistemic justice: A critically reflexive examination of 'sanism' and implications for knowledge generation. *Studies in Social Justice, 10*(1), 59–78.
Marchenko, G. (2016). *Still life*. Downers Grove, IL: Intervarsity Press.
Merkin, D. (2017). *This close to happy*. New York: Picador.
Merleau-Ponty, M. (1964). Indirect language and the voices of silence. In Signs (R. McCleary, Trans.) (pp. 39–83). Evanston: Northwestern University Press.
Nolen-Hoeksema, S., & Hilt, L. M. (2009). Gender differences in depression. In I. H. Gotlib & C. L. Hammen (Eds.), *Handbook of depression* (pp. 386–404). New York: The Guilford Press.

Orange, D. (2020). Silence in phenomenology: Dream or nightmare? In A. Dimitrijević & M. B. Buchholz (Eds.), *Silence and silencing in psychoanalysis: Cultural, clinical, and research perspective* (pp. 7–25). London: Routledge.
Osler, L. (2021). Controlling the noise: A phenomenological account of anorexia nervosa and the threatening body. *Philosophy, Psychiatry, & Psychology, 28*(1), 41–58.
Peck, D. (2013). Current Approaches to the Assessment of Depression. In M. Power (Ed.), *The Wiley-Blackwell handbook of mood disorders* (pp. 391–412). Oxford: Wiley-Blackwell.
Perkins, A., Ridler, J., Browes, D., Peryer, G., Notley, C., & Hackmann, C. (2018). Experiencing mental health diagnosis: A systematic review of service user, clinician, and carer perspectives across clinical settings. *The Lancet: Psychiatry, 5*(9), 747–764.
Potter, N. N. (2019). Voice, silencing, and listening well. In Ş Tekin & R. Bluhm (Eds.), *The Bloomsbury companion to philosophy of psychiatry* (pp. 305–324). London: Bloomsbury.
Price-Robertson, R., Obradovic, A., & Morgan, B. (2017). Relational recovery: Beyond individualism in the recovery approach. *Advances in Mental Health, 15*(2), 108–120.
Radden, J., & Varga, S. (2013). The epistemological value of depression memoirs: A meta-analysis. In K. W. M. Fulford, M. Davies, R. Gipps, G. Graham, J. Sadler, G. Stanghellini, & T. Thornton (Eds.), *The oxford handbook of philosophy and psychiatry* (pp. 99–117). Oxford: Oxford University Press.
Ratcliffe, M. (2015). *Experiences of depression*. Oxford: Oxford University Press.
Ritunnano, R. (2022). Overcoming hermeneutical injustice in mental health: A role for critical phenomenology. *Journal of the British Society for Phenomenology*. https://doi.org/10.1080/00071773.2022.2031234/
Rose, D. (2017). Service user/survivor-led research in mental health: Epistemological possibilities. *Disability & Society, 32*(6), 773–789.
Sartre, J.-P. (1947). Republic of silence. In A. J. Liebling (Ed.), *Republic of silence* (pp. 498–500). New York: Harcourt, Brace & Co.
Scrutton, A. P. (2017). Epistemic injustice and mental illness. In I. J. Kidd, J. Medina, & G. Pohlhaus (Eds.), *The Routledge handbook of epistemic injustice* (pp. 347–355). London: Routledge.
Solomon, A. (2015). *The noonday demon* (2nd ed.). Vintage.
Spencer, L. (2021). *Breaking the silence: A phenomenological account of epistemic injustice and its role in psychiatry*. PhD thesis. Bristol: University of Bristol.
Stanghellini, G., Broome, M., Fernandez, A. V., Fusar-Poli, P., Raballo, A., & Rosfort, R. (Eds.). (2019). *The Oxford Handbook of Phenomenological Psychopathology*. Oxford: Oxford University Press.
Styron, W. (2004). *Darkness visible*. London: Vintage.
Tanesini, A. (2018). Eloquent silences. In C. R. Johnson (Ed.), *Voicing dissent.* London: Routledge.
Tekin, Ş, & Outram, S. (2018). Overcoming mental disorder stigma: A short analysis of patient memoirs. *Journal of Evaluation in Clinical Practice, 24*(5), 1114–1119.
van Elferen, I., & Raeymaekers, S. (2015). Silent dark: The orders of silence. *Journal for Cultural Research, 19*(3), 262–273.
van Hooft, S. (2003). Pain and communication. *Medicine, Health Care and Philosophy, 6*, 255–262.