European Journal for Person Centered Healthcare 2019 Vol 7 Issue 3 pp 499-505

ARTICLE

Listening well to psychiatric service users: What does it mean to give uptake?

Nancy Nyquist Potter PhD

Professor Emerita, Department of Philosophy, Adjunct with the Department of Psychiatry and Behavioral Sciences, University of Louisville, Louisville, KY, USA

Abstract

Communication is central to good healthcare, with clinician, patient, and family members all playing a key role in identifying the needs and treatment options for the patient. Because good healthcare is person-centered, communication needs also to be person-centered - with the patient as the primary focal point - even though there may be several other parties who have interests and concerns for the patient. But in what does good communication consist? This article delves more deeply into the question of what is entailed in listening well, expanding on the concept of uptake as introduced by J.L. Austin. I apply uptake to psychiatric service users; because of persistent stigma, implicit bias, and stereotyping, this population faces some unique challenges when it comes to being listened to and taken seriously, This is especially true for members of Black, minority and ethnic groups. While the focus of this article is on uptake, I also discuss some kinds of silencing that may be at play in clinical encounters and in co-production. However, many questions are left unanswered as to when and how uptake is properly given, and when, if ever, it should not be given. The final section of this paper speaks to the need for others to engage in research and practical engagements so that this vitally important practice can be taught and employed. Here, I raise a number of questions that need to be addressed in order for a deeper understanding can develop about what it means to give uptake well.

Keywords

Communicator, co-production, epistemology, listener, mechanisms of silencing, person-centered healthcare, silence, voice, uptake

Correspondence address

Prof. Nancy Nyquist Potter, 1364 S. 1st St., Louisville, KY 40208, USA. E-mail: nancy.potter@louisville.edu

Accepted for publication: 22 July 2019

Introduction

Communication is central to good healthcare, with clinician, patient, and family members all playing a key role in identifying the needs and treatment options for the patient. Because good healthcare is person-centered, communication needs also to be person-centered - with the patient as the primary focal point, even though there may be several other parties who have interests and concerns for the patient [1]. But in what does good communication consist? This article examines the question of what is entailed in listening well, expanding on the concept of uptake as introduced by J.L. Austin as it applies to giving uptake to psychiatric service users [2]. This population faces some unique challenges when it comes to being listened to and taken seriously, due to stigma, implicit bias and stereotyping. While the focus is on uptake, I also discuss some kinds of silencing that may be at play in clinical encounters and in co-production. Because many questions arise as to when and how uptake is properly given and when, if ever, it should not be given, the final section of this paper speaks to the need for others to engage in research and practical engagements so that this vitally important practice can be taught and employed. In this section, I raise a number of questions that need to be addressed in order that a deeper understanding can develop about what it means to give uptake well.

I am primarily concerned with experiences of service users of psychiatry, who often feel as if they are not truly listened to and not taken seriously as knowers who can contribute to knowledge production [3]. This ranges from clinical encounters to forensic psychiatric service users to participants in co-production. Co-production is an organizing effort between various healthcare service providers, policymakers and service users to include the voices, resources and skills of service users in the development of better services. Intrinsic to mental health policy for over 20 years now, the contributions of service users are recognized as important and there is more talk about "'choice and control' in the personalisation and recovery agendas, but the evidence on how well this works out in practice is mixed" [4]. This is particularly true for members of Black, minority and ethnic groups who have a

mental illness [4,5]. Multiple structural disadvantages combined with stereotyping and stigma exacerbate the lack of credibility accorded members of such intersectional groups. In mental healthcare, service users are often taken as less credible due to their mental illness or distress. Thus, it is crucial to create spaces that allow for them to be in a high degree of control over how their communications get exercised and interpreted. Thus, a matrix of concepts are implicated in communicating well with service users: having/using a voice; silence/being silenced and giving and receiving uptake. What is at stake is the very possibility of communicating and of genuinely being heard. These issues are vital to consider because of their potentially deep effects on epistemology, ethics and treatment plans, as well as policymaking.

Theorizing uptake

Most of us occasionally employ the concept of uptake, especially when we do not receive it. For example, a service user involved in the co-production of an outreach program for the homeless mentally ill in rural areas might be asked how her ideas were received at the last meeting. She might reply, 'I got no uptake whatsoever. Everyone nodded politely and then ignored it'. Despite good intentions, this is a more common experience than we might imagine - whether such responses come from service users or other stigmatized and/or marginalized people who try to participate in team meetings. There is a theory behind this everyday experience, which derives from the philosophy of language and which focuses on speech as a kind of action. J.L. Austin argues that some speech acts are a subset of actions, meaning that they *perform* actions, not just cause them or refer to facts. The speech acts that perform actions are called 'illocutionary'; that is, the utterance *constitutes* an action. Additionally, some illocutionary acts must produce a particular effect on the listener in order for that speech act to count as successful. Securing the utterance as successful is what Austin calls 'uptake' [6].

An example of what Austin means by a 'successful illocutionary act' is that of saying 'I do' in a marriage ceremony: a person's marriage vows are not considered to be successful if the listener does not recognize and understand the importance of those words. My move in understanding both successful uptake and failures of uptake is to expand the notion of communication. As I have stated, my current focus is the question of what it means to give genuine uptake to service users. By 'giving uptake,' I mean that communications (including, but not limited to, speech) are 'successful,' where being successful is broader than Austin's account, but nevertheless engages with it. 'Uptake' is often not an event, however, but a temporally extended experience, which makes it more complex to pin down the notion of 'success'. It also does not need to signify agreement, but rather *an epistemic stance of openness to the communicator's understandings*. Thus, communication is not only a matter of that which constitutes or performs an action, or of that which persuades or causes an action, but also that which contributes to knowledge-production. Communication, in my theorizing about uptake, includes bodily comportment, certain kinds of silence, gestures and even the way a person dresses.

An Austinian account of uptake is a very specific kind of speech act that assumes linguistic and social conventions in order to secure the utterance and count it as successful. Yet reliance on speech or other communicative conventions may miss the mark when it comes to listening, understanding and appropriately responding to a service user's communications [7]. That is, relying on 'appropriate responses' or speech conventions may not come across as actually giving uptake. It could instead feel as if one's humanity as a knower is called into question [8]. It could spark distrust. In the Danish novel *What My Body Remembers* [9], Ella Nygaard has been in has been in foster care since she was a young girl. At age 27, she has run away for what she hopes is the last time; she is in hiding so that she can retain her freedom from interventions and consequences of her past, sometimes violent, behavior. Eventually, a social worker finds her anyway. Ella comments, 'Hennig looked genuinely interested. Curious. Helpful. He was a man who had mastered the entire catalog of verbal and nonverbal expression. I made a mental note that I would never be able to trust him' [10]. The point I want to emphasize is the necessity of going beyond response conventions**.** Ella does not trust conventional communications toward her because she questions the sincerity of such expressions of concern and care.

One might wonder whether it matters that the uptake given is genuine or not, as long as the communicator believes that she is being understood and taken seriously; does it not move dialogue forward even if not sincere? Some, perhaps many, service users are able to sense when the listener is not seriously engaging with their perspective and communicative attempts. Disingenuous uptake undermines attempts at epistemic equality and fuels alienation and distrust. But even if the communicator cannot sense disingenuousness, it is not a virtue to treat listening - or the communicator - as purely instrumental. As Fricker emphasizes, being taken seriously as a knower is a central component of a meaningful and ethical life [11]. Elsewhere, I argue that giving uptake is a virtue in the Aristotelian sense and this article maintains that view although I do not detail it here [6,12].

A second way in which uptake can seem to the listener not to be given when speech conventions are followed may come in the form of acknowledging an idea or complaint, but then explaining why she should not feel this way. In a team meeting for a person who had been brought into emergency psychiatry for substance abuse problems, the service user eventually exclaimed, in effect, 'no one is listening to me! I'm outta here!' My observation was that, indeed, her complaints were not being addressed but rather explained away in an effort to make her understand what was required of her.[1] Genuine exchange of knowledge,

[1] It could be, though, that some members of the healthcare team were giving the service user uptake but trying to explain the ways that she had misunderstood or misinterpreting the situation. It is not the case that one only receives uptake when one is being agreed with. It did seem to me that the healthcare team were dismissing her complaints, though.

experience and emotions did not occur because the service user's communications were not engaged with. The healthcare team had a practice and typical response for how to manage 'problem substance abusers' and was not able to take in her concerns. Important knowledge was lost due to their inability to learn from the service user's concerns. Furthermore, the possibility of an effective treatment plan was overthrown when she left in frustration. With the rise of co-production that includes service users' voices and experiences, 'there's a growing realisation that people don't simply have needs that have to be met; they have assets (experience, skills and expertise)' that can contribute to knowledge and even change the structure and content of what counts as knowledge [5]. Finally, a failure to give uptake highlights ethical problems when this occurs: undermining the epistemic status of a service user harms her not only epistemically but ethically, as it contributes to an experience of ethical loneliness - the isolation one feels when abandoned by humanity, or by those who have power over one's life possibilities [13].

A third way that following communicative conventions may be experienced by the communicator as discounting her claims, or 'not getting it', can occur when the needs of the communicator do not fit into trained models of conventional responses. This example differs from the previous one in that the previous case emphasizes the way in which the communicator's complaints were explained away due to preconceived ideas about substance abusers. In the following case, the listener takes the communicator seriously, especially with respect to the listener's understanding of the suffering of rape victims. Yet he misses the mark, and I suggest that this happens because the listener is trapped by the limits of speech conventions. In the BBC production of *Shetland* [14], Tosh, a police officer, was raped while on duty. When talking about it later, Jimmy, her supervisor, says he finds it hard that she feels she has anything to be ashamed of:

> Tosh: 'I walked straight into it. I didn't see the signs. How *stupid* does that make me?!'
>
> Jimmy: 'No, No! This is not about anything you did or didn't do.'
>
> Tosh: 'I'm police.'
>
> Jimmy: 'What, this is your fault?'
>
> Tosh: 'How is it not? I'm police. I'm trained. I should have known better.'
>
> Jimmy: 'Tosh, he did this, not you.'
>
> Tosh: 'Yeah, but I made it easy for him.'

Jimmy did everything right, according to training in how to talk with rape victims. Yet Tosh simply was not at a point where his comments were helpful: she needed to deal with her position as a police officer before she could move on to accept that she was not to blame. Jimmy missed an opportunity to engage with her in what she was focusing on. Tosh left the discussion clearly upset.[2] In summary, attention needs to be given to the mechanisms through which experiences and needs that fall outside of the extant terrain of representation may be closed off or distorted [15].

Finally, giving uptake well requires that we learn "how to hear, interpret, and act upon evidence from testimonial sources *not commonly accorded authoritative voice*" [16]. Testimony is a kind of evidence and one thing that we rely on, in weighing testimony, is the norms that govern conversation. David Hume's idea is that we predict a person's likelihood of telling the truth based in part on whether he, or persons like him, tend to follow the norm in situations like this. Suppose Bill were trying to decide whether or not to believe some claim that Allan makes. Bill would want to know not only whether the claim is plausible, and whether or not Allan is in a position to know about this claim, but also what sort of person Allan is. Bill makes a determination about the credibility of Allan, in part, based on whether or not Allan is likely to deceive or mislead him. If he learns that Allan is a member of a synagogue where Bill's previous exposure to that group has indicated that they conform their testimony to the truth, this gives Bill a reason to believe that Allan is a credible speaker. That is, Bill infers that Allan follows a communicative convention of honesty that members of that synagogue hold [17].

The evaluation of testimony is thus not only an individualist task; it calls upon the listener to make evaluations based on background noise about who counts as knowers, what counts as knowing and what counts as knowledge. These judgments are socially and culturally shaped. Put simply, some groups are considered less credible than others, not because they have 'earned' that judgment, but because epistemological hierarchies situate them as less trustworthy both epistemically and ethically. Epistemic oppression thus plays a basic function in maintaining certain structures of knowledge while dismissing or not even registering other knowledges [18]. The experiences of service users are routinely discounted due to stereotyping and stigma, even when listeners are committed to not perpetuating epistemic and other forms of oppression within medical epistemes. It is much more difficult to give uptake when we (perhaps subconsciously) perceive communicators to lack credibility just in virtue of their being members of certain groups - in this case, persons living with mental distress or illness. So what gets in the way of well-intentioned clinicians and others giving uptake?

Mechanisms of Silencing

In this section, I discuss just three of the mechanisms of silencing that can occur between service users and clinicians or within co-production teams. I employ the term 'mechanism' after Foucault's work because it captures the

[2] Notice that, in this case, Jimmy was not getting uptake either; neither one of them could receive the other's communications in a way that directly engaged with the other's perspective.

idea of unexamined or subconscious social epistemologies at play in silencing:

> 'The key idea of the archaeological method is that systems of thought and knowledge (epistemes or discursive formations, in Foucault's terminology) are governed by rules, beyond those of grammar and logic, that operate beneath the consciousness of individual subjects and define a system of conceptual possibilities that determines the boundaries of thought in a given domain and period' [19].

These epistemes are mechanisms of power and control (again, not implicating individual intention) and this is how I am using the term 'mechanism.'

Just as Foucault argues that the ways we conceptualize and experience sexuality are inescapably shaped by specific cultural conventions and mechanisms of power, I argue that the possibilities and limits of what can occur during conversation and communication, in clinic or in co-production, are shaped by systems of power and cultural conventions [19]. I identify three mechanisms here, starting with material discussed in 'Theorizing uptake' above.

Following speech conventions

Uptake and silencing bear a complex relationship to one another. A failure to give uptake does not always result in the communicator being silenced; sometimes misfirings occur and the communicator may feel misunderstood but not necessarily silenced. Silence can also be active or passive. It can be a form of disengaged behavior (being resigned), self-protective behavior and other-oriented behavior [20]. Nevertheless, silence is a form of communicating - or, I might say, silence *communicates* - consciously or otherwise. What is important at this juncture is that resigned or defensive silence can be a result of intentional or unintentional silencing behavior on the part of the listener(s). The communicator may become silent because they do not perceive that the listener has given, or is able to give, them uptake on a particular issue, or in the particular style of getting their point across (e.g., Latina and Black women routinely are dismissed because they are 'too angry' in their communications when listeners confuse anger with passion, or by assuming that energetic anger is dangerous; service users of all colors may be dismissed because they do not follow conversational norms of Western and Northern rationality). The point is that speech conventions also may reflect and reinforce structural oppression. For example, to not remain open to the possibility that service users have knowledge that bears significantly on how to understand not only their world, but the shared world(s) in which we live and make sense of ourselves and others, perpetuates systematic prejudices about who knowers are and can be.

Silencing can also be the result of threats or perceived threats. Here, the speech convention seems to be working as Austin intended it, in that the threat is given uptake: the listener recognizes the speech act and responds to it as a threat; thus, the speech act 'comes off' with the appropriate response. Consider this example from a person in forensic psychiatric care:

> But at the same time I don't always dare to say what I think … I don't dare to say to them [the carers], when they are not kind to me and shout at me do this do this, then I am quiet, not saying a word and doing as they say … [And how do you feel inside then?] … I feel as though I am a coward, a slave or something … disgusting … [You said a slave … in which way do you feel that you…?] That I belong to them, they control me or something like that, fascists, or I don't know … [What sort of feelings do you get when it comes?] I am most often disgusted with myself … [What would you like to do in such a situation?] Say what I think, tell them to "shut up" … to put it bluntly, "Just shut up," but then I'm scared that they'll make it worse for me … [What do you think would happen if you did so?] They'd go for me and put me into the admissions ward and take away all my privileges and make sure that I would be here ten years more [21].

The service user has given uptake to the threat. However, note that the fear of being punished for speaking one's mind results in defensive silencing. This is a survival tool in the face of danger, but we run a significant longer-range loss over time because repeated silencing can cause us to lose our voice, to doubt ourselves epistemically and to develop habits of acquiescence.

Changing the subject

A second mechanism of silencing is what I call 'changing the subject.' This has a double meaning in that it includes both changing the topic of the service user's conversation and, literally, changing the conception of the subject himself or herself. For example, a service user says to her therapist, 'I hate my body. I am having a seriously bad fat-body day' and the therapist pauses and then replies, 'How has your job been going?' Here, the person's topic does not receive uptake from the clinician and the experience is of the subject of conversation being changed without a segue. This might occur because the psychiatrist is preoccupied, or simply did not hear what the service user said. But, sometimes, it happens because the topic introduced by the service user is uncomfortable to listen to, or it is an old theme and the clinician does not want to engage with it again. Even so, giving uptake to the service user should come first, meaning that the speaker needs to be responded to with an attempt to understand her perspective before moving in a different direction. However, this may not always be the case, a point I return to in the Conclusion.

Another way we might silence others in the mode of changing the subject is literally to reposition the communicator from a person to a mentally ill patient. When a member of a co-production team thinks (and possibly communicates subconsciously), 'He sounds like a conspiracy theorist, thinking everyone in authority is against him; he sounds pretty paranoid', we risk constructing the person who is describing a process problem as a disordered and untrustworthy patient. We shift him from a participating person at the table to someone we situate in a medicalizing episteme. It is true

that our subjectivity is never wholly under our own control; subjectivities are in flux, never entirely stable, as we take up others and position them according to the social imaginary [16]. Still, some repositionings are severely damaging, as when we interpret someone as mad, a terrorist, or a criminal without adequate evidence.[3]

Microaggressions

A third mechanism of silencing is that of microaggressions. These are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of marginalized groups [22]. Whether in clinic or co-production environments, service users experience microaggressions in various forms. One is that of microinsults, which are statements or actions that indirectly belittle a marginalized person. For example, a psychiatrist may call in the parent of an adult, competent service user, and then talk primarily with the parent. While this is likely to be an attempt on the part of the clinician to increase understanding of the service user's current struggles by gaining a broader perspective, the service user herself may feel humiliated and rendered invisible by the shift in attention away from her and to her parent. She may see her parent as being given more uptake than she herself has received. This can result in the service user feeling invisible and deciding that there is no point in trying to insert oneself into the conversation.

Another form that microaggressions can take is that of microinvalidation: statements and behaviors that negate or nullify a marginalized person's experiences or realities. An example would be to assume that a service user's anger or defiant behavior is merely a symptom of illness or a primitive defense mechanism being acted out [6]. The service user's anger thus is negated or trivialized and not engaged with as a real-time anger about a current subject or relationship. Microinvalidations may be subtle, but they can be quite damaging: the service user may end up feeling 'crazy' or at least perceived and treated as such. It may leave him feeling very lonely and abandoned.

Many other mechanisms of silencing occur that this article cannot address. But, in summary, kinds of silencing are both epistemically and ethically damaging to the communicator and can lead to a loss of knowledge for both or all participants:

> Silencing is one of the areas in which we cannot separate out communicative and epistemic agency: it is because of impoverished communicative dynamics without reciprocity and uptake that epistemic trust cannot be established and credibility is undermined; and when epistemic subjectivity and agency are seriously compromised, the subject's communicative capacities cannot be recovered and she will enjoy, at best, an inferior voice in the interaction [23].

[3] This is tricky, too, because what counts as evidence itself is shaped by practices and epistemes that largely are controlled by privileged and powerful people. A full theory of giving uptake, my broader project, would include a discussion of how to rethink the very concept of evidence.

Discussion

Many issues remain unaddressed in this article, but I here point toward some of the questions that would need to be addressed for a richer theory of giving uptake to service users to be developed.

Being silenced and being silent may be two different modes of communication. Sometimes, being silent may be an assertion of one's boundaries. When asked about his alcohol consumption, Peter may respond that he does not want to talk about it. Peter gives uptake to the question by stating that he closes off that topic. If the clinician persists, on the grounds that knowing the answer to this question is vital to the selection of the psychopharmacological treatment for Peter, has the clinician now refused to give uptake to Peter's refusal? Or is this more an issue of disagreement, a form of argument-dialogue [24]?

More broadly speaking, is it ever okay to refuse to engage a person on a topic? Of course, clinicians are trained to keep clinical encounters on a professional level, which in part means that they do not share personal information. Even here, though, it may be the case that the clinician is giving uptake to a personal question by explaining that he is not going to answer the question and why. It is important to emphasize that giving uptake does not mean that one agrees with the communicator. Furthermore, each clinician needs to decide what sorts of questions from a service user are unproblematic to answer, given their particular history and the context in which the question arises. In co-production, the issue is even less clear because the professional/service user divide is deliberately challenged and relationships are aimed at equality. Nevertheless, it may sometimes be appropriate not to give uptake and not to engage in a person's communication - as when an abusive ex-partner continues to call, pleading and threatening, or when one's teenager continues an old argument with the same points made that were addressed in several previous conversations.

Another question is what it would look like to give uptake to a person who is paranoid or psychotic. Laticia had taken out a restraining order on her ex-boyfriend. Today, she reports that he has visited the property, sending oblique threatening messages. She has not actually seen him there, but she sees that items have been moved and strategically placed to frighten her. She also reports a number of calls from an unlisted number where no one speaks when she takes the call. She is frightened. What would appropriate uptake to her concerns be? Should the clinician reassure her that this is part of her illness and that she knows she can become paranoid - that perhaps they could increase her medications for a time? Or should he engage with her safety concerns and take her reports at face value? Ultimately, this may be a question of how to perceive and understand what it means to say that a person has a psychosis or is paranoid - and how to determine when signs of epistemic difficulty are affecting how that person experiences her world at that moment.

A crucial question is that of who gets to decide when uptake has been properly, or adequately, given. Although space does not permit me to argue for this claim, I suggest

that the disadvantaged, marginalized, and/or racialized person be given some deference in claiming that she/he/they are not being heard, not listened to appropriately. Thus, the more powerful or authoritative people in a healthcare team or in co-production bear more of the burden of epistemic responsibility to be good listeners and to take to heart claims that they are not hitting the mark.

Lastly, we might wonder what the temporal mode of successful uptake is, although this question is beyond the scope of this article. Does it need to occur right in the moment of the communication or can the listener(s') uptake occur later, even weeks or months later? Does it disrupt the relational aspect of giving and receiving uptake if too much time has elapsed between communicator and giving uptake? How much time is 'too much'?

There is no one universal answer as to what counts as appropriate responses in most, if not all, cases. My examples in this article do not provide a full case history or a context in which dialogical exchanges occur, and giving uptake in such examples may turn out to be different depending on context, history of the relationships and so on. Still, I suggest that there is a better or worse way to respond to epistemic and other communicative claims from service users and one can get closer to good responses or further away from them.

Conclusion

Service user participation invokes a relational epistemic structure. Ideally, it involves reciprocal responding that makes it possible for new shared knowledge to emerge. It can be thought of as an invitation for each to respond to the other and calls upon all participants to notice, acknowledge and understand signifying gestures, body language, and comportment, as well as speech. For genuine uptake to occur, then, means that the listener takes seriously her responsibility as a receiver of testimony to give a distinctly reflexive social awareness. The preventive work needed to minimize the possibility of service-users being misunderstood, erased, or silenced, requires that we 'critically examine patterns of communicative interaction and the discursive and imaginative resources through which different groups and their standing in society are conceptualized and talked about' [25]. Thus, one aim of clinical work should be to cultivate an ethos of attentiveness to distortions and deprivations of voice and of listening. One antidote to distortions, microaggressions, and other mechanisms of silencing, is to develop the virtue of listening well - that is, giving uptake.

Conflicts of Interest

I declare no conflicts of interest.

References

[1] Person-Centred Training and Curriculum Scoping Group and the Special Committee on Professional Practice and Ethics. (2018). Person-centered care: implications for training in psychiatry. London: Royal College of Psychiatrists. Available at: https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2018-college-reports/cr215.

[2] Austin, J.L. (1962.) How to do Things with Words. Oxford: Oxford University Press.

[3] Kalathil, J. & Jones, N. (Guest eds.). (2016). Special Issue: Critical underpinnings of user/survivor research and co-production. *Philosophy, Psychiatry, and Psychology* 23: 3/4.

[4] Kalathil, J. (2008). Dancing to our own tunes: Reassessing black and minority ethnic mental health service user involvement, 1-52. Available at: www.ccmediagroup.co.uk (last accessed 7 July 2019)

[5] Coldham, T. (2012). Co-production: why Scie is giving a bigger voice to service users and carers. *The Guardian* Tue 26 Jun 2012.

[6] Potter, N.N. (2016). The Virtue of Defiance and Psychiatric Engagement. Oxford: Oxford University Press, ch. 6.

[7] Potter, N.N. (2000). Giving uptake, *Social Theory and Practice* 26:3, 479-508.

[8] Fricker, M. (2007). Epistemic Injustice: Power & Ethics of Knowing. p.5. Oxford: Oxford University Press.

[9] Friis, A. (2017). What My Body Remembers, (translated by L. Falk van Rooyen), New York, New York: Soho Crime.

[10] Friis, A. (2017). What My Body Remembers, (translated by L. Falk van Rooyen). p. 202. New York, New York: Soho Crime.

[11] Grasswick, H. (2014). Understanding epistemic normativity in feminist epistemology. In The Ethics of Belief (ed. J. Matheson and R. Vitz.). pp. 216-243. Oxford: Oxford University Press.

[12] Potter, N.N. (2009). Mapping the Edges and the In-between: A Critical Analysis of Borderline Personality Disorder. Oxford: Oxford University Press, 2009.

[13] Stauffer, J. (2015). Ethical Loneliness: The Injustice of not Being Heard. New york: Columbia University Press.

[14] British Broadcasting Corporation One. *Shetland*. Original release (2013). 2013-present.

[15] Norval A. (2009). Democracy, pluralization, and voice. *Ethics & Global Politics* 2(4): 297-320.

[16] Code, Lorraine (2008). Advocacy, negotiation, and the politics of unknowing. *Southern Journal of Philosophy* 46 (S1) 32-51.

[17] Root, M. (2001). Hume on the virtues of testimony. *American Philosophical Quarterly* 38 (1) 19-35.

[18] Dotson K. (2014) Conceptualizing epistemic oppression. *Social Epistemology* 28 (2) 115-138.

[19] Gutting, G and Oksala, J. (2019). "Michel Foucault", *The Stanford Encyclopedia of Philosophy* (Spring 2019 Edition), Edward N. Zalta (ed.), Available at

https://plato.stanford.edu/archives/spr2019/entries/foucault/ (last accessed 7 July 2019).
[20] Van Dyne, L., Ang S., and Botero, I. C. (2003). Conceptualizing employee silence and employee voice as multidimensional constructs. *Journal of Management Studies* 40 (6) 1359-1392.
[21] Hörberg, U., Sjögren, R. & Dahlberg, K. (2012). To be strategically struggling against resignation: The lived experience of being cared for in forensic psychiatric care. *Issues in Mental Health Nursing* 33 (11) 743-751.
[22] Sue, D.W., Capodilupo, C.M., Torino, G.C., Bucceri, J.M., Holder, A.M.B., Nadal, K.L. & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist* 62 (4) 271-286.
[23] Medina, J. (2013). The Epistemology of Resistance: Gender and Racial Oppression, Epistemic Injustice, and the Social Imagination. p. 95. Oxford: Oxford University Press.
[24] Walton, D. (1984). Logical Dialogue-Games and Fallacies. Lanham, MD: University Press of America.
[25] Medina, J. (2013). The Epistemology of Resistance: Gender and Racial Oppression, Epistemic Injustice, and the Social Imagination. p. 250. Oxford: Oxford University Press.