**Bright-siding and truthfulness about experiences of illness**

*Nottingham ICONIC seminar 4/4/23*

I offer an analysis of the phenomenon Barbara Ehrenreich calls ‘bright-siding’ and argue that it involves failures to be truthful about the complexities of experiences of illness: it obstructs authentic discourse.

1. **Preliminaries.**

An ideal of **pathographic truthfulness**: one important feature of good illness narratives is truthfulness, in the sense of showing fidelity to the realities of those experiences:

* a rhetoric of faithfulness to one’s experiences (Carel), ‘honouring stories of illness’ (Charon), ‘bear[ing] witness to what goes into coping’ (Frank).
* admiration for ‘raw’, ‘courageous’, ‘tell-it-like-it-is’ pathographies.

Initial problems:

* the rhetoric is sometimes mere rhetoric – in practice, one does something different.
* it is not always truthfulness *qua* truthfulness being admired; truthfulness gets admired insofar as it serves a further, more esteemed value or aim (eg authenticity, defiance, provocation).

Further complications:

1. the complexity of being truthful – accuracy, sincerity, fidelity to one’s sense of what matters.
2. the variety of philosophical accounts of truthfulness (Williams – Miller – etc.)
3. uncompelling accounts of pathographic truthfulness (Sontag on ‘purgation’ of metaphor).

 The idea of truthfulness about experiences of illness: experiences of illness are diverse, complex, and complexly contextually textured, articulable in terms of different narratives, metaphors, and styles

 Distinguish:

1. truthfulness about one’s own experiences.
2. truthfulness about others’ experiences.
3. truthfulness about our shared experiences of illness.

 Moreover, consider some deeper kinds of truthfulness about experiences of illness:

1. phenomenological articulation of the existential structure of experiences of illness (Carel).
2. ‘metaphysical’ idea: illness discloses fundamental truths about ‘the human condition’, so particular acts of truthfulness can gesture towards more general truths about human life (cf. Carel and Kidd on ‘facts of life’).
3. **Bright-siding.**

We can get a clearer view of pathographic truthfulness by considering kinds of failure to be truthful about the complexities of illness: the phenomena Ehrenreich, in *Smile or Die*, calls ‘**bright-siding**’.

 BSing refers to a diverse set of mutually-reinforcing tendencies to ‘turn away from’, ignore, dismiss, downplay, or otherwise fail to engage appropriately with the ‘darker sides’ of human experiences. We can distinguish different levels – or locations – of BSing:

1. an internalised feature of agents – attitudes, dispositions, stance, mindset.
2. a feature of interpersonal interactions and relationships – sustained by norms and practices.
3. a mood or ethos of a culture manifested in its preconceptions, entrenched scripts and values, and manifesting in collectivised behaviours, and often accompanied by legitimising theoretical structures (Ehrenreich on BSing as an aspect of a wider ‘ideology of positive thinking’).

BSing has diverse topics – in principle, any topic with negative aspects – and has many **modes**:

 **Attenuation**

1. Denying or failing to properly acknowledge the dark sides
2. Downplaying or understating the reality, scale, extent, and severity of the dark sides.

**Amplification**

1. Exaggerating the likelihood, brilliance, and compensatory quality of the ‘bright sides’.
2. Emphasising positive possibilities without due acknowledgement of their rarity and costs.

**Constraints**

1. Promoting narratives that present positive outcomes as typical, normal, or inevitable.
2. Imposing and enforcing narrative norms that constrain the content, structure, and expression of pathographic testimonies (eg content and tone policing).

**Derogation**

1. Pathologisation or demonization of the desire to attend to the ‘dark sides’.
2. Derogation and condemnation of pathographic truth-speakers (ttention-seekers, ‘perverse’).

 BSing can also involve, *inter alia*, glossing over, sugar-coating, heroising, glamorising, or romanticising experiences of illness—all shaped by master narratives, social and cultural norms, etc.

1. **Truthfulness and authenticity.**

BS-ing obstructs pathographic truthfulness and the kinds of authentic interpersonal connection which it can sustain.

1. **Modes of bright-siding can merge**: triumphalist illness narratives ‘decline to struggle over the many questions for which there seem to be few answers. In essence they shrink from the complexity of their experience […] adhering to the culturally preferred narrative of triumph, authors typically downplay or deny other dimensions of their own experience’ (Conway).
2. **Specific** **instances of bright-siding can be appropriate, even necessary** – we should not rush to condemn it *tout court* or think of truthfulness as an ‘unconditional will to truth’ (Nietzsche).
	* the emotionally distressing or disturbing reality of the dark sides.
	* the pragmatic and therapeutic need, at times, to turn away from the dark sides.
	* the variable, often unpredictable responses of people to raw, viscerally honest truths.
	* the interpersonal rewards of bright-siding.
	* the interpersonal costs of ‘dark-siding’.
	* the cultural entrenchment of bright-siding narrative norms and expectations.
	* the entanglement of bright-siding with religious, cultural, and political narratives.
3. **Bright-siding obstructs a kind of pathographic truthfulness which is a precondition for kinds of authentic interpersonal connection.**
* pathographic truthfulness will often involve acknowledging, ‘speaking’, exploring, and being truthful about the dark sides of experiences of illness.
* the bifurcation of experiences of illness into ‘bright’ and ‘dark’ sides is untenable: the bright/dark distinction immediately falsifies the experiences, and any omission of the dark sides necessarily compromises the bright sides. BSing doesn’t tell ‘half the truth’, but, as it were, less than half – ‘a fraction of the truth’ (Ann Boyer, *The Undying*)

 So, there is a kind of pathographic truthfulness that involves articulating the complexity, messiness, and ambivalence of experiences of illness – and the uncertainty, struggle, and efforts of coping which those experiences entail. Without a truthful apprehension of someone’s experiences, one cannot seek certain kinds of authentic connection with them – ones rooted in apprehension of their predicament.