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THE POWER OF STORIES: RESPONSIBILITY FOR THE USE OF AUTOBIOGRAPHICAL STORIES IN MENTAL HEALTH DEBATES

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Abstract: Autobiographical stories do not merely offer insights into someone’s experience but can constitute evidence or even serve as self-standing arguments for a given viewpoint in the context of public debates. Such stories are likely to exercise considerable influence on debate participants’ views and behaviour due to their being more vivid, engaging, and accessible than other forms of evidence or argument. In this paper we are interested in whether there are epistemic and moral duties associated with the use of autobiographical stories in mental health debates. We argue that debate participants have a responsibility to assess a story as evidence or as an argument when the story is put forward to support a given viewpoint. We also make some preliminary suggestions about what can be done to ensure that the use of stories contributes to the variety of the resources available to debate participants without compromising the quality of the argumentation or increasing polarisation.

Keywords: moral responsibility, epistemic responsibility, autobiographical stories, arguments, evidence, public debates, mental health.

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1. Introduction

By being exposed to stories, we can be informed, entertained, challenged, educated, motivated, inspired, and antagonized. Storytellers might have some explicit goals when they tell a story, but the story can have further effects that it is difficult for them to predict and control. That is because stories have both intended effects – the ‘explicit aims of storytelling’ – and unintended effects, that is, roles that are independent of the intentions of the storytellers.¹ When a mother reads a bedtime story to her child her primary aim may be that of entertaining the child. But depending on the contents of the story and on the way the child engages with it, the story may also teach the child something (what dinosaurs ate) or inspire the child to behave in a good way (be kind to others).

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¹ See for instance, Gabriel (2000) and Jackson (2002).

A common unintended and unwanted effect of exciting bedtime stories is that children get scared and have nightmares.

The success conditions of a story are relative to the role that the story is intended to play. A story can at the same time succeed at motivating people to act in a certain way and at building a strong sense of identity and pride, and fail to convey accurate historical information, as it often happens with myths and legends. The criteria used to evaluate stories should map the roles that stories have. Aesthetic judgement might tell us whether an autobiographical story is beautifully told, whether it is well-thought out and memorable, but some fact-checking is required to establish whether the story truthfully represents the author's life.

Some autobiographical stories are offered in support of a debated viewpoint – not just as illustrations of a general point, but as evidence for an argument or as a self-standing argument. When stories are used as evidence or as arguments, a number of interesting issues emerge about their use that philosophers have not explored in detail yet. There are epistemic concerns about what participants in a debate can learn from an autobiographical story and in which circumstances, if any, such a story can serve as good evidence or as a good argument for a given viewpoint. There are also moral concerns: do participants in debates have a responsibility to assess stories as evidence or as arguments, and what resources should be made available to them to do so? Such questions are motivated by the conviction that the use of stories impacts on the shape of the debate and on the quality of subsequent contributions to it. There are some reasons to believe that the use of autobiographical stories can elicit identity beliefs and increase polarisation, whilst also generating empathetic responses in people who defend a different view.

In this paper, we focus on the use of autobiographical stories in public debates on mental health. We believe that in the context of mental health autobiographical stories raise additional issues, because they can inform research and clinical practice; they create, challenge, or perpetuate either positive or negative stereotypes associated with some non-typical experiences; and they shape self-perceptions, contributing to either self-stigma or self-advocacy. We will address the significance of autobiographical stories and the responsibility we have in using them within a debate, focusing on two examples, the debate about how to think of and treat unusual experiences and beliefs (trauma-informed vs. biomedical models), and the debate about how to conceive of autism (neurodiversity vs. illness/disability). In the former debate, participants are interested in how to best conceptualize mental distress and in the latter, they are interested in the status of autism. Notwithstanding the differences in content, the two debates share some important structural features. First, in both debates, stories are used to shape and inform people's perceptions. Second, in both debates, first-person accounts are testimonies of a viewpoint that other participants cannot directly access unless they also have lived experience of mental distress or autism. Our aim is not to contribute to the substantive issues addressed in the two debates, but to draw attention to the contribution of autobiographical or personally significant stories to the public discussion.

2. First-person accounts in mental health

First-person accounts of mental health in the public domain (be these autobiographies, blog posts, comments to articles, or tweets) are a valuable resource for researchers and clinicians and allow readers to better understand experiences that may initially be puzzling to them, such as thought insertion or hearing voices, from the perspective of the person who is having those experiences. When people with lived experience have the inclination and the opportunity to describe their unusual experiences, this can inform how caregivers, healthcare professionals, and the wider public approach mental health issues. First-person accounts also help to counteract prejudice. One example of the beneficial role of stories is Roberta Payne's powerful first-person account of living with schizophrenia, *Speaking to My Madness: How I Searched for Myself in Schizophrenia*.² In the book she describes how schizophrenia disrupted her life on several occasions, forcing her to give up some of the things she valued most (such as her studies and her close connection with her family). However, Payne found the strength to reclaim such things in time and be in a position where she could manage the effects of paranoia and other symptoms. Her *memoir* challenges a common conception of schizophrenia 'as a death sentence' and a condition that cannot be successfully managed.

Stories about autism also play a crucial role in shaping public perceptions, especially the perceptions of those who do not have direct experience of living with autism or caring for autistic people. But even for those who do have some experience of autism, stories offer new resources to interpret behaviour and to understand autism better. For example, *The Reason I Jump* is an autobiographic book by an autistic boy, Naoki Higashida, who describes his experiences and explains how they affect his behaviour. In the introduction to the book, David Mitchell, translator of *The Reason I Jump* and father of a child with autism, acknowledges the enormous influence the book had on his understanding of some of the challenges faced by his own son.³

Stories about mental health inform and educate. As we saw, Payne's *memoir* conveys how disruptive schizophrenia can be and yet offers hope that it can be managed. Other examples of this come from the impact of stories about autism. In a paper on autism biographies, Ian Hacking notes that Mark Haddon's novel *The Curious Incident of a Dog in the Night Time* is used as a textbook for training teachers of children with special needs.⁴ In the introduction to his book *Neurotribes*, the author Steve Silberman reveals that for a long time all he knew about autism came from watching Berry Levinson's film *Rain Man* (1988). The children's TV programme *Sesame Street* introduced a character with autism, Julia, to help children learn about the condition. By including stories about Julia, differences in behaviour which characterise autistic people and which might otherwise be misinterpreted are explained to a young audience.

² Payne (2013).

³ Higashida (2014).

⁴ Hacking (2009a).

3. Stories and stereotypes

There is a danger in sharing stories about mental health, whether these stories are fictional or autobiographical. Readers may overgeneralize from the vivid individual case of one person living with a specific condition to all cases of people living with that condition. There is copious empirical evidence that we tend to generalise information about other people, and in particular perceive people from other groups as more similar to each other than people from our own group: this is the phenomenon often called *outgroup homogeneity*.⁵ Such a widespread cognitive tendency affects how we respond to stories about mental health. However, details of a story do not easily generalise to other people and there are risks in associating a certain condition with behaviour that has either positive or negative connotations.

For example, Ian Hacking points to the danger of romanticizing autism and falling victim to the error of thinking that all autistic people have some special talent that non-autistic people lack.⁶ Similarly, schizophrenia and bipolar disorder are often romanticised. Some psychotic experiences are presented as enlightened states people can enjoy when they escape from imposed social conformity and come into contact with a deeper self. Mania is often associated with creativity, enhanced productivity, and originality of thought;⁷ depression with a special depth and breadth of understanding and feeling, more valuable than the sugar-coating with which optimists go through life. According to some critics, Sofia Coppola's movie, *The Virgin Suicides* (1999), is an example of how depression can be presented as dreamlike and almost seductive, despite leading to self-destruction.

Stories also highlight aspects of behaviour that can give rise to harmful stereotypes. In crime stories, schizophrenia is often mentioned as the diagnosis of serial killers and other master criminals, in combination with irresponsible news reporting, this contributes to a common association between schizophrenia and violence. The fact that overgeneralisation is a risk in the consumption of individual anecdotes, autobiographies, and works of fiction does not mean that stories about mental health should not be told. Rather, the power of stories to influence public perceptions should be acknowledged, leading to a more responsible consumption of stories. The aim should be for the public to be able to access a varied diet of stories about people living with one condition, which could for instance be achieved by ensuring a balanced coverage about, say, autism or schizophrenia in the media.⁸ By accessing different first-person accounts of people living with the same condition, it would be easier to avoid romanticizing or demonizing mental health challenges, and to undermine associations between behaviours and diagnoses that are not confirmed by evidence.

Readers [...] need to be more critical when faced with stereotyped autistic characters – as they now are with a range of other minority representations. When encountering characters from vulnerable or minority groups, we must all learn to ask who is doing the writing, why, and on what authority.⁹

⁵ Allport (1954).

⁶ Hacking (2009b).

⁷ Gillett (2005).

⁸ Sarrett (2011).

⁹ May (2018).

Studies revealing widespread misconceptions are a powerful reminder that we should use stories about mental health *responsibly*, keeping in mind that a story can have a variety of positive and negative effects, some more predictable and some rather surprising. People who write about their own or their family's mental health, or write fiction including characters experiencing various forms of distress do not necessarily intend to shape public perceptions. Nevertheless, their stories may have effects which go far beyond their original intentions as storytellers. As we mentioned above, Haddon's *The Curious Incident of the Dog in the Night Time* became a teaching resource, even though it was not designed as such.

Stories about mental health, as we saw, inform, educate, and shape public conceptions. They also shape how people see themselves.

[S]tories about autism are contributing to the formation of a discourse about autism. They suggest ways in which autistic people can choose to express their experiences. They suggest ways in which neurotypicals can think about the lives of others. Only in the past couple of decades have we begun to acquire such ways of speaking.¹⁰

Stereotypes deriving from autobiographical stories offer people ways in which they can conceptualise their own behaviour. At times, people identify with and relate to the associated features; at other times they react against them.

4. The mental health wars

Case studies, thought experiments, and anecdotal evidence often contribute to supporting arguments in a debate,¹¹ but so far there has been no systematic philosophical investigation into the use of autobiographical stories as evidence or as arguments. We believe that this investigation is particularly urgent when it applies to public debates in mental health. Not only do stories exercise a powerful influence on the participants in a debate, but their influence often outweighs that of evidence or arguments that are presented more formally or less vividly, such as arguments based on statistical evidence or clinical cases.¹² And yet, stories do not usually come with an indication of how typical the narrated event is.¹³ Given that stories can be so powerful, it is useful to develop the resources to critically assess them in their role as evidence or arguments.

Some people who experience distress attract a diagnosis of schizophrenia. On which model should interventions and support be based? There is a lively debate on this issue, which we might regard as an appropriate theme for a philosophy conference or a controversy between more medically-orientated psychiatrists and less medically-orientated clinical psychologists. However, there is one version of this debate that can be described as 'public'. That is because (1) it does not involve only scholars but the general public; (2) its consequences affect not just one academic speciality, one profes-

¹⁰ Hacking (2009b): 514.

¹¹ See for instance, Moore and Stilgoe (2009); Cubitt (2003); and Markovits and Schmeltzer (2007).

¹² Jones and Anderson Crow (2017).

¹³ Tracy (2012).

sional body, or the health service, but the whole of society; and (3) it is conducted using a variety of media: social media such as Twitter and Facebook, online fora and blogs, and the popular press.

Due to space limitations, we will offer only a brief summary of the main views in the debate. According to the biomedical model, distress should be interpreted as the sign of the person being ill or disordered, conceptualized in medical terms and treated primarily by medical means. Just as sneezing may mean that you caught a cold, seeing or hearing things that other people cannot perceive, or believing things that other people find implausible may mean that you are having a psychotic episode. The assumption is that diagnosis is fallible, but useful. Reporting your unusual experiences and beliefs may lead to a psychiatric diagnosis, maybe one of schizophrenia, which to some sounds like a death sentence, because of the common conception of the disorder as something severely disruptive and chronic. In contrast to being told that one is coming down with a cold, being diagnosed with a mental disorder can be very stigmatizing and that is one of the reasons why some argue that (some) psychiatric diagnoses should be avoided.¹⁴ Another reason why the practice of diagnosing mental disorders is under fire is that it is believed by some to be unreliable, lacking both scientific validity and clinical utility.

The critics of psychiatric diagnosis often reject the biomedical model in favour of alternative models that take into account the social and psychological context in which distress emerges and acknowledge that the adversities the person might have previously encountered in her life contribute to the distress she is now experiencing. To address the limitations of the crude versions of the biomedical model, the biopsychosocial model has been developed. It emphasises the role of psychological and social factors contributing to distress, from bullying and migration to poverty and abuse. The newly introduced Power-Threat-Meaning (PTM) framework is an even more radical departure from the biomedical model than the biopsychosocial model, as it is often described as leaving the biological and medical dimensions entirely behind to build on the intuition that distress is ultimately a way of coping, a response to threats caused by power imbalances, inequalities, and adversities.¹⁵

Our goal here is not to assess and compare different models of distress but to examine the way in which the public debate unfolds, focusing on arguments for the best explanation of distress and the most effective responses to it. The debate on the merits and limitations of the PTM framework involves clinical psychologists, psychiatrists, people with lived experience, caregivers, academic philosophers, mental health activists, and more broadly members of the public with an interest in mental health. It is not easy to summarise the reactions to the framework as they are very diverse. In short, the framework seems to speak to many people who experienced distress and had a history of trauma, because they see their earlier traumatic experiences as causally linked to their current distress, and to people who for various reasons did not find the diagnostic labels

¹⁴ Johnstone and Boyle (2018).

¹⁵ While the PTM framework is a new development, it picks up on well-established strands of thought from authors such as Thomas Szasz and R.D. Laing, who also tried to re-describe psychiatric illnesses as arising from and manifestations of interpersonal conflicts rather than illnesses which are located in the individual.

attributed to them or their loved ones accurate, helpful, empowering, or conducive to effective treatment. On the other side of the debate, people and organizations have objected to the framework because it can be interpreted as rejecting psychiatric diagnosis and pharmacological treatment altogether, even describing them as unethical practices to be discontinued in the long run. Yet, the framework does not seem to have the resources to propose an adequate, scientifically respectable, and practical alternative to diagnosis and treatment as they are currently practised (see Larkin 2018 for an extended commentary on the framework). The concern is that the framework will not be able to account satisfactorily for those cases of distress that are not related to trauma and that the strong tones of the authors' polemical agenda are not matched by a proposal that can indeed replace current practices.

Some of the arguments for and against the PTM framework have been based on autobiographical or personally significant stories. To what extent have such stories succeeded in advancing the debate?

5. Should we 'drop the disorder'?

If the PTM framework is right and distress is not caused by some intrinsic state of the person, a deficit or a dysfunction, but is a product of a number of interrelated factors including previous adversities, then talking about 'mental illness' may be misleading in that it appears to focus on issues that can be confined to the person alone, instead of including the social context in which the person has been raised or lives her life. Nick Webb wrote a piece for *The Independent* about his mother's suicide and how a conception of mental health different from the biomedical one 'could have saved her'. The piece relies heavily on the author's mother's story, and the recognition that tragic events in it had an impact on her wellbeing,

My mum had a controlling father in childhood who stopped her pursuing her life's ambitions. She was forced into a caring role as the oldest of four siblings and in place of her absent parents, and she suffered the death after only six weeks of her second baby. She experienced alcoholism, domestic violence and a near-complete lack of financial freedom in marriage, as well as the MS and loss of mobility she developed in her fifties and the excruciating shame she felt for being sectioned by the state in her sixties.¹⁶

After describing his mother's predicament in this way, Webb concludes that, when facing a person in distress, we should ask her "What happened to you?" rather than "What is wrong with you?" arguing that this would lead to a more compassionate approach to their distress. Webb explicitly cites the PTM framework as a welcome development in the way we think about mental health. It is interesting that the argument ends with a pretty general conclusion about what we should do when facing a person in distress, but the evidence in support of the conclusion relies almost entirely on the details of his mother's life story. How generalizable is the case of Webb's mother to other people experiencing distress?

¹⁶ Webb (2018).

Expressing a more critical view of the PTM framework, Linda Gask wonders why it did not help her make sense of her own distress.

I didn't experience anything like the trauma many of my patients did, but I was shamed and criticized, physically punished and experienced a degree of emotional neglect and absent parenting. The PTM framework doesn't help me personally to make sense of that, although a therapist with a strong allegiance to it might think differently and want to try and convince me so. Neither does it help me to understand why my brother, alone amongst the members of our family, developed obsessive-compulsive disorder at the tender age of 7. I have spent my life, since my very helpful therapy ended, coming to terms with my grief for the childhood that I did not have [...]. I would have found the PTM framework helpful in understanding my battles with power in the NHS, and paradoxically perhaps with managers of psychological therapy services in particular when trying to increase access to therapy. But it still doesn't explain why I amongst my colleagues was the one who got severely depressed. For that I would still argue a 'biopsychosocial' framework is still needed.¹⁷

In her thoughtful commentary, Gask argues that the PTM framework has been useful to her in some respects but cannot completely replace existing models of distress because there are some cases (notably, her own case and her brother's case) that do not fit the model. In particular, Gask argues that the framework has difficulty explaining how many people experience adversities but only some of those people go on to manifest behaviour that causes distress to them and attracts the attention of mental health professionals.

6. Hospitalisation and medication

If the PTM framework is right and distress is not the symptom of a disorder, then we should not treat people who experience distress as if they were ill. This has a number of consequences for the measures to be taken to alleviate people's distress. For instance, according to models like the PTM framework, pharmacological interventions may not be an appropriate response and should not be recommended by healthcare professionals to people experiencing distress. Rather, if distress is an effect of people's previous trauma and adversities, understanding people's life experiences and alleviating the effects of such traumatic and adverse events may be the most productive response in the short term – in the long term, it is likely that institutional changes focused on preventing adverse circumstances, such as abuse and poverty, from affecting young people, will be required.

One of the points Webb makes is that his mother's diagnosis and her being brought to hospital did not help her feel better and did not encourage her close circle of family and friends to understand what was going on.

¹⁷ Gask (2018)

When Mum was sectioned 10 years ago, professionals told our family that she was psychotic and needed to be taken to hospital and given medication. The follow-up care from mental health professionals felt half-hearted and ineffectual. Seeing her sitting alone in the hospital garden, head bowed low and motionless, contributed, along with her clinical diagnosis, to everyone around her feeling that she was “other”; that she was untouchable and irretrievably ill. Today’s public policy and service culture give too much weight to the individual as cause of the problem. When someone is unemployed, for example, we say it’s because they need to be more resilient or hard-working, rather than looking for social and economic causes. Or when someone is mentally “unwell”, we look for illness within the person, and the wider and external forces remain invisible.¹⁸

Here, as in the previous quote from Webb’s article, the critique of individualism in psychiatry is based on the effects of the treatment his mother received on herself and on her family and friends. Webb makes his point very eloquently and what he says is most convincing, but both sources of evidence for his conclusion would need to be further examined to establish whether they can provide direct support for the general claim he wants to make. After reading the piece, we are left unsure as to whether his mother did experience any relief from her symptoms as a result of her treatment – we are only told that “care *felt* ineffectual”.

7. The neurodiversity debate

We now want to turn to a special use that stories are put to in the context of autism, which is to support certain viewpoints in the neurodiversity debate. Before discussing the use of stories, we will give a brief overview of the questions at issue in the neurodiversity debate.

In autism advocacy, there is an ongoing battle as to whether autism should be understood as an illness or merely as a psychological and neurological difference. The neurodiversity movement advocates the latter understanding, whereas concerned parents of children who are severely autistic frequently champion the understanding of autism as an illness and look for a cure. Neurodiversity advocates argue that understanding autism as a disorder or illness is misguided because illnesses are something that people have, whereas autism is an integral part of the way a person is. If one sees autism as an illness, so the argument, one devalues the way an autistic person is. They further argue that understanding autism on a deficit model unjustifiedly takes what is statistically normal, i.e. neurotypical individuals, as the benchmark for what is right, or functions correctly. Being different from neurotypicals, so the argument goes, is not the same as being dysfunctional.¹⁹

The neurodiversity movement is driven by people who are diagnosed as highly-functioning autistic. There is a certain amount of variation within the movement, as some object to the disorder label strongly, whereas others see autism as analogous to

¹⁸ Webb (2018).

¹⁹ Jaarsma and Welin (2012).

disability in that it constitutes a real handicap but, rather than seeking a cure, society should make sure that the people with autism have full access to the opportunities open to neurotypical members by accommodating their needs. These issues are complicated by the fact that the concept of mental disorder or disease people are working with is not always well defined. Different associations and conceptions of what it means to be a disease or disorder feed into the reasons for accepting or rejecting a model. So, for example, if we take a disorder to be something that calls for a cure or for eradication, then this will affect how people react to the claim that autism is a disorder. Generally, the connotation of the disease concept that people react against is that there is something biologically wrong with people with autism. Interestingly, the claim of biological or neurological *difference* is often embraced, but the normative connotations of harmfulness, dysfunction and undesirability are rejected. Conversely, some aspects of the disorder label are considered desirable even by people who reject the disease model, for example the notion that there should be accommodation at school and in the work place, benefits, or therapeutic interventions available to people with autism.

Many of the proponents of a conception of autism as a disorder or a disease see it as a condition which should ideally be cured, although this is not a necessary consequence of the conception of autism as a disorder. One could defend that conception on the grounds that the condition comes with certain deficits, while also thinking that the condition should not be cured or eradicated because it is central to a person's identity.

Proponents of alternative conceptualisations of autism use various kinds of arguments to make their point. Some argue that the behaviour of people with autism is not the effect of deficits but merely a profile of strengths and weaknesses that is not neurotypical.²⁰ Others argue that because a disease model conceptualizes a mental disorder as something external to the person, something a person has, it should not apply to a condition that a person has from birth and that fundamentally shapes their way of perceiving the world, their personality traits, and so on.²¹ Proponents of the scientifically dubious view that autism is a curable disease caused by vaccinations such as J.B. Handley draw on scientific studies and papers to bolster their position. But autobiographical stories also play an extremely influential role in arguing for a specific way of conceptualizing autism and convincing audiences that the chosen conception of autism is the right one. Autobiographical stories of experiences with autism encapsulate core experiences in a vivid and recognizable format – and they shape readers' understanding of autism. Stories have a persuasive punch that a collection of data just cannot equal.

The debate about the nature of autism is, to put it mildly, heated. People with high functioning autism are usually on the neurodiversity side of the debate and parents of children who are severely autistic or people who experience their condition as burdensome are on the disorder side. When people are arguing against each other, they are not just concerned about who can prove their case. They are also worried about what the dominant narrative about autism will be and how it will affect them or their loved one personally. This is why stories play such a central role in shaping the debate.

²⁰ Jaarsma and Welin (2012).

²¹ See Kapp, Gillespie-Lynch, Sherman and Hutman (2013) for a study on perceptions of autism.

By now, it is well known that autism is a spectrum condition and that in some cases, the condition is hardly noticeable to the casual observer, whereas in others, the existence of a significant mental health problem will be obvious. Even though autism can manifest in very different ways, and there is some awareness of that in the general public, we still have a mental stereotype of autism, as embodied either in the seriously socially challenged person who has problems with language, or in the slightly introvert and socially awkward computer scientist from next door. If the latter stereotype becomes dominant, one concern is that it will weaken the case for support and interventions (“They can manage”). If the former stereotype prevails instead, and the disease narrative wins, then people with autism may be dehumanized as a result (“They are not like us”). Both sides of the debate rightly feel that they have something to lose if the dominant stereotype of autism becomes one that does not match their experience. This largely drives the polarisation of the debate.

8. Stories about neurodiversity

Consider the following extract from a blog post entitled ‘Neurodiversity: Just say No’ in which autistic author Jonathan Mitchell criticizes the neurodiversity movement:

I am a diagnosed autistic, nonverbal, feces smearing at age 3, 8 year veteran of special education yet I do not share this view. I long for a cure for autism though a cure at age 52 is not the same as at age 3, even in the unlikely event of a cure being found in my lifetime. Somehow I got missed when they took the census. So they are incorrect about all or most autistics. Is this a viable philosophy that will help autistics and their families? Is there a consensus for this philosophy among most autistic persons? Are the people who espouse this philosophy typical of autistic people in general? I would like to address these questions in this piece. My problems are many. I have been fired from multiple jobs and had to retire from paid work at 51 (I am 52 now). I have never had a girlfriend. Sometimes I would make above average errors at work, though there was some discrimination as well, this does not fit in with neurodiversity’s solution of accommodation.²²

Mitchell uses his own experience of autism as evidence against neurodiversity claims, and moves from individual experience to the claim that neurodiversity advocates are “incorrect about all or most autistics.”

Stories are also used to further the other side of the debate: in his book *Neurotribes*, Stephen Silberman recounts a story by Ari Ne’eman, an autistic neurodiversity campaigner. Ari Ne’eman describes the way his environment reacted following his diagnosis of autism at the age of 12:

Suddenly I went from being someone that people believed had a lot of potential, to someone who surprised people by any positive attribute that I might display. Before, everyone focused on the things that I was good at, the things that I wanted out of

²² Mitchell (2007).

life, and the subjects I was interested in. After I was diagnosed, everybody focused on the things I struggled with, and the things that made me different, which were often the same things that people had framed as positive before.²³

In the short passages above the authors use personal experiences as a way of making a point about the condition of autism in general. In the blog post, Mitchell insists that his experience is not compatible with the position that autism is merely a difference which we can work around by accommodating the needs of people diagnosed with autism (for example, making some changes in the workplace to reduce sensory overload will not solve all the problems faced by people with autism at work). He gives two short anecdotes which make his situation really vivid, one about his childhood and then again about the problems he encounters in his job and with relationships.

In the context of mental health debates, personal anecdotes and stories enable storytellers to share their experience of living with a condition with other people who might not have the same experience. Mitchell draws on his own experience to show us what suffering autism can cause. Ari Ne'eman (and Silberman, by including the story in his book) uses his story to show that labeling people as 'autistic', not autism itself, creates an impairment. Both storytellers draw on experiences that are not available to those who are not directly affected by autism, and their stories help the audience realise what the experience of an autistic person may be like in certain situations. Both stories make use of the storytellers' privileged position of access from experience to drive a point home. But does the authority storytellers have in reporting an experience from the inside carry over to the further viewpoints they intend to support by sharing the story in a given context? Can we learn from their stories without believing that the conclusions they drew from their experiences will generalize to other similar cases of autism or to autism *tout court*?

Advocates of neurodiversity such as Temple Grandin also tell anecdotes about the cognitive advantages the condition confers, as well as illustrating differences in perception among autistic people, and between people who are autistic and people who are not.

When I was much younger, I assumed that everybody perceived the world the same way I did, that everybody thought in pictures. Early in my professional career I got into a heated verbal argument with an engineer at a meat-packing plant when I told him he was stupid. He had designed a piece of equipment that had obvious flaws to me. My visual thinking gives me the ability to 'test-run' in my head a piece of equipment I've designed, just like a virtual reality computer system. Mistakes can be found prior to construction when I do this. Now I realize his problem was not stupidity; it was a lack of visual thinking. It took me years to learn that the majority of people cannot do this, and that visualization skills in some people are almost nonexistent.²⁴

Autobiographical stories can be used in conjunction with other kinds of arguments for a position regarding the nature of autism. The autism activist and anti-vaccine

²³ Silberman (2015), chapter 11.

²⁴ Grandin (2008), chapter 2.

campaigner J.B. Handley likes to lend his statements on autism a scientific air by citing statistics and scientific research papers extensively. But he, too, uses personal anecdotes to support his argument. In the quote below, he compares his own experience of the prevalence of individuals with a diagnosis of autism with his children's experience, arguing that in their generation autism is much more widespread than it was in his own.

I'm approaching fifty years old, and as a child I'd never seen or heard of even one peer with autism. Ask any teacher, doctor, nurse or coach who has been working for three decades or more and you'll always hear the same thing: something very new and very different is happening with children today. My teenage children know dozens of kids with autism, and schools are bursting at the seams with special education classes [...] Unfortunately, the Good Doctor is like a guy with a small limp and a cane representing paraplegics to the world. His story is fascinating and compelling but bears little resemblance to the autism most parents, myself included, actually deal with every single day.²⁵

Handley moves from the claim that there are more children diagnosed as autistic in his children's peer group than there were in his own, to the claim that there is an autism epidemic. He ignores the fact that these personal experiences could be equally well explained by local differences (maybe there are fewer children with an autism diagnosis in other schools) and also dismisses a more plausible explanation, which is that changes in diagnostic practices have led to the increase in children diagnosed as autistic. It is possible for instance that current diagnostic tools are more sensitive than those previously used, or that the decrease in the stigma associated with autism makes it more likely for people to seek help when they experience challenges at school. Sometimes stories are used to bolster claims that they would only really provide evidence given a raft of further assumptions.²⁶

9. Developing strategies for a responsible use of stories

What does it take to be responsible about the way we use stories as evidence or as arguments in public debates? As pointed out above, (1) autobiographical or personally significant stories carry some authority, because they offer some insight into direct experiences that are often relevant to the debated issues, and (2) can be more powerful than other ways of defending a viewpoint, because they are made more salient and memorable as an argument by their reference to a person's life events. This is especially true in mental health, where the experience of the storyteller may not be one that the audience shares. However, telling a story about an experience that others may not be

²⁵ Handley (2018): 17.

²⁶ In fact, the very observation Handley lists, that there has been an increase in diagnoses, is used as evidence of over-diagnosis in other debates about mental illness, such as the one we described above on the medicalization of distress, for example by the authors of the Power Threat Meaning Framework (Johnstone and Boyle 2018). This is a clear example of how one and the same observation can be made to support diametrically opposed conclusions.

able to experience directly and providing an engaging and salient contribution to the understanding of a specific condition are not the same thing as defending a viewpoint in a debate. Although a personal story is well suited to draw attention to some previously neglected issues, it is not the best way to establish a general claim. Personal stories are by their very nature bad at providing support for comprehensive theories, because they are about the experience of one person.

Logically, the fact that one autistic person tells a story that suggests that she is disordered (or not-disordered) at most underwrites an existential claim. For example, depending on the content of the story, it could underwrite the claim that some autistic people are disordered (or that some autistic people are not disordered). Similarly, if for one person who is experiencing distress due to previous adverse events can at least in part account for the distress she is experiencing, this does not tell us that distress can always be accounted for by previous adverse or traumatic events, but that in some situations a trauma-informed account might work. At the same time, a person finding medication useful in dealing with her distress does not prove that medication is always helpful in dealing with distress, but suggests that it can be at least a partial solution for some. The fact that there are so many stories available to us that pull the debates in opposite directions seems very instructive. Maybe, autism makes some people (feel) disordered, and other people (feel) just different from the statistical norm. Maybe, distress has a variety of causes and can be addressed in different ways depending on the life history of the person involved, and other factors too.

This means that when people hear stories that are used as arguments in a debate they have the responsibility not to retain some critical distance despite the vividness of the story and its other merits (its aesthetically pleasing features, its capacity to move and inspire, its important role in building and reflecting identities, and so on) and ask whether the story actually is a good argument for the viewpoint it is used to support. This is at the same time an *epistemic* duty, as it helps people navigate complex issues and assess different types of evidence and arguments fairly, leading to debates where the influential positions are better argued for; and a *moral* duty, as it helps the debate take a shape that reflects the weight of the evidence and inform policies and behaviours leading to better outcomes. Of course, the responsibility we are describing should not be viewed as a burden imposed on participants in a debate. Effective tools for the critical evaluation of stories as evidence and as arguments need to be developed and widely shared.

Although more research is needed to establish what such tools might be, and whether they would have the expected results, we can make some suggestions here about strategies that might help build a critical distance from stories used as arguments. Maybe, if we want debates to become more inclusive and less polarized we should get storytellers from opposite sides of the debate to share a platform. By being exposed to stories with different underlying messages, the audience could acknowledge the complexities of an issue and accept that people with mental health challenges can be more or less disabled by their condition, and that different approaches will be needed to respond to distress in different people depending on their life histories and other factors. What does sharing a platform entail? It could be part of a *balancing* strategy: a story that presents one side of a complex issue can be accompanied by another story that presents another side

of the same issue, where the desired outcome is to promote a more balanced view of a controversial situation. An example of the balancing strategy would be for readers to actively seek out, and be supported in finding, a variety of stories about autism, some where it is presented as neurodiversity and some where it is described as a disorder. This would ensure that readers are exposed to the reality of the different ways in which autistic people see their predicament and see themselves.

In addition to platform sharing, another strategy could be promoted, inviting an evaluation of the strength of the conclusions drawn on the basis of stories. In a *contextualising* strategy, a single story could be filled out with more relevant details and used as an argument for a narrower claim than the one originally made, if there is no evidence in the story backing up the broader claim. An example of the contextualising strategy would be for readers to be mindful of sweeping generalisations following the sharing of personal experiences. This does not mean that the story itself should not be appreciated and taken seriously, but that the conclusions drawn by the storyteller should be considered as an important contribution to a debate if they reflect the contingencies of the narrated events. For instance, the suggestion is that at the end of Nick Webb's article readers should ask themselves what his mother's story shows. Does it show that all mental health challenges should be seen as caused by trauma, or that some people experiencing psychotic symptoms can benefit from having their stories heard?

10. Conclusions

Storytellers participating in mental health debates often have a personal stake in their stories becoming the dominant ones, and it is too demanding to expect that they themselves engage in balancing and contextualising strategies. However, both the people who disseminate stories, such as the media, and those who actively participate in the debate can and should be expected to use stories responsibly and to be supported in exercising their critical judgement. Whereas it is undesirable to live in a society where storytellers are silenced or policed for the stories they share, or where their contributions are censored, it is paramount that we all become aware of the different roles stories can have and take a more active role in examining whether a story that is used as an argument in a debate is a good argument for the viewpoint it defends. That is why we should promote initiatives that enable people to develop a critical distance from compelling and engaging stories.

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