Towards a literary account of mental health from James' *Principles of Psychology*

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**Abstract**

The field of mental health tends to treat its literary metaphors as literal realities with the concomitant loss of vague “feelings of tendency” in “unusual experiences”. I develop this argument through the prism of William James’ (1890) *The Principles of Psychology*. In the first part of the paper, I reflect upon the relevance of James’ “The Psychologist’s Fallacy” to a literary account of mental health. In the second part of the paper, I develop the argument that “connotations” and “feelings of tendency” are central to resolving some of the more difficult challenges of this fallacy. I proceed to do this in James’ spirit of generating imaginative metaphors to understand experience. Curiously, however, mental health presents a strange paradox in William James’ (1890) *Principles of Psychology*. He constructs an elaborate conception of the “empirical self” and “stream of thought” but chooses not to use these to understand unusual experiences — largely relying instead on the concept of a “secondary self.” In this article, I attempt to make more use of James’ central division between the “stream of thought” and the “empirical self” to understand unusual experiences. I suggest that they can be usefully understood using the loose metaphor of a “binary star” where the “secondary self” can be seen as an “accretion disk” around one of the stars. Understood as literary rather the literal, this metaphor is quite different to more unitary models of self-breakdown in mental health, particularly in its separation of “self” from “the stream of thought” and I suggest it has the potential to start a re-imagination of the academic discourse around mental health.

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1. **Introduction**

There are unacknowledged fault lines of tension between the literary and the literal in James’ *Principles of Psychology* which set an interesting context for current debates in mental health. In particular, his description of experience is profoundly metaphorical and imaginative. Thought is one moment a “Stream” (Vol. 1, p. 85); another “herd of cattle” (Vol. 1 p. 337) and another a “bird” flying and perching (Vol. 1, p. 243). Biology, on the other hand, and his linkage of the brain to the self are quite literal. The self of selves (the spiritual self), for instance, is analyzed all the way down to “peculiar motions in the head or between the head and throat” (Vol. 1, p. 301, italics). Dewey (1940) was one of the first to pick up this tension, arguing that James’ naturalism leads towards an unfulfilled biological — behaviorist account of experience which uncomfortably coexists with a parallel account of a “psychic” subject. Similarly Schuetz (1941) argues that James’ ascription of thought to cerebral conditions is rejected by phenomenology but his description of the “stream of thought” and “theory of fringes” finds an intriguing parallel with Husserlian phenomenology and more recently Gale (1999) has referred to *The Divided Self of William James*. There is the “Promethean” James, one who creates as much as discovers meaning in multiple worlds governed by interests, and the “mystical” James, who puts his faith in the absolute state of the universe and its constants (including its biological constants).

While James was writing in 1890, this fault-line is still being contested in mental health today. Symbolic, experiential accounts are still squaring off against literal biological and cognitive-behavioral accounts of the root causes and treatments for mental health issues (see, for instance, the Maudsley debates, *Kings College London*, 2016). The symbolic placebo effect is quite effective as a treatment for “mental illness” (Healy, 2008), which allows skeptics to cast doubt on the more literal medical treatments (Breggin, 2008; Moncrieff, 2008). Similarly “non-specific” factors such as the therapeutic alliance lead sceptics to doubt the efficacy of talking therapies including “Cognitive Behavioral Therapy” (e.g. McKenna,
2001; Parker, Roy, & Eyers, 2003). Diagnostic labels are challenged as stigmatizing and unhelpful by some of those who receive these labels with the persistency of labels becoming a source of academic curiosity (Pilgrim, 2007) and there is a debate as to whether the evidence from brain scans of “mental illness” is really a creative interpretation of oxygen levels (see Thomas, 2014, for an interesting critique of brain imaging). Moves towards a consensus position, such as the “biopsychosocial” model of mental health (which leaves some scope the literal and the literal to coexist) have arguably been unsuccessful, precisely on account of “biomedical self-confidence” (Pilgrim, 2002) around the medical causation of mental illness.

So what makes James relevant to these disputes when, in his own work, the differences between the literal and the literary pass by unremarkably? He is relevant because his metaphors, similes and analogies are under-utilized in these present-day debates (with the important exception of Leudar & Thomas, 2000, as we will see in section three). There are good reasons for this neglect, such as James’ own reluctance to draw on his account of the “empirical self” to discuss “pathology.” However, James is worth a second look and the timing for a renewal of interest is good. Despite the clashes between the literary and literal, in “evidence-based” government parlance, such an account of “empirical self” does exist in the American National Institute for Health and Care Excellence in Britain and the Food and Drug Administration in the United States, the prevailing view is that mental health diagnoses and treatments should follow a literal path. As a consequence, Cognitive Behavioral Therapy and medication have emerged as the dominant treatment methods in Anglo-American mental health practice. Both frameworks are compatible with the demands of this evidence base, where diagnostic definitions come with a detailed set of symptoms and specific time-scales (such as those provided by the DSM or ICD); the severity of the symptoms is open to measurement through symptom rating scales (such as the Hamilton Rating Scale or the Brief Psychiatric Rating Scale); and clear comparisons between interventions, as one finds in randomly controlled trials, is possible. In fulfilling these evidence-based requirements, concepts invariably become more literal.

The public ubiquity of these literal models of mental health leads to a risk of “epistemicide” (Bennett, 2007) where an alternative to the dominant knowledge is lost or rendered invisible. Such epistemicide is already occurring in the public sphere, with evidence-based, medical approaches dominating the public imagination (Boyle, 2013). What is at stake in current academic debates is more than just resistance against epistemicide, however; it is also the development of an experiential, humanistic understanding of mental health. This is evident in the move towards the development of an experiential, humanistic understanding of mental illness. This is more than just resistance against epistemicide, however; it is also a problem for first-person accounts of experience. The difficulty for the introspectionist (e.g., how to overcome the gap between an experienced thought and its reporting) is also a problem for contemporary psychology, where there is now a more institutionalized division between first-person and second-person accounts of thought.

One advantage of second-person accounts of thought from the professional perspective in psychology is that they allow for a common vocabulary for problems and a common or overlapping framework for treatment. Hence, mainstream treatments, such as CBT and medication for mental health problems use and share a common vocabulary for the target problems with thought, e.g., “thought disorder”; “obscene thoughts”; “alien thoughts” or “hallucinations”; “delusional thoughts”; “disembodied thoughts”; “paranoid thoughts.” In mainstream mental health these problems within the stream of thought are possibly symptomatic of even graver, more enduring conditions (such those enumerated in the DSM and ICD; e.g., “depression,” “schizophrenia,” “bipolar disorder”). This means that a diagnosis can lead to both a course of medication and a course of CBT simultaneously or sequentially, notwithstanding paradigmatic differences.

It is important to point out that this second-person account may exist only as a higher-order abstraction, perhaps useful only for case-notes or for enabling patient access to specialist services/in-surance benefits, and in that sense co-exist as re-interpreted first-person accounts (Barrett, 1996). Treatment will emerge from a common professional vocabulary of diagnosis but aim to target the personal problems the patient experiences. Difficulties arise however when the psychologist’s professional vocabulary does not map onto the experience of these thoughts, from within the thought itself, as James would say. For example, someone who putatively suffers from cognitive errors may not experience them as errors but rather as depressing realities (Boyle, 2002).

Drawing on James’ (1890) discussion of the “psychologist’s fallacy,” Giorgi (1981) refers to this kind of disagreement between perspectives as “intersubjective confusion.” The scientist’s perspective is confused with the patients’ perspective. From this point of view, the fallacy is overcome when patient and scientist share the same perspective. This is precisely what happens through what is considered education or therapy, when patients may learn to speak about their thoughts using the same terms as the professional psychologist and report their observations of their thoughts as the psychologist would. In this sense, as Stanley (2012) argues, introspectionism is public and rhetorical. For example, both patient and therapist may adopt what Frank (1995) refers to as the “restitution narrative”: illness is temporary and, through medical technology, may be cured. The patient now has a means of making
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