From Hinge Narrative to Habit: Self-Oriented Narrative Psychotherapy Meets Feminist Phenomenological Theories of Embodiment

Jennifer Hansen

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In what follows, I offer some friendly amendments to Potter’s psychotherapeutic model—‘the hinge narrative’ (HN)—designed to help bipolar patients cultivate self-trust. My primary contribution is to suggest an alliance between narrative theory and feminist phenomenological theories of embodiment. I argue that these projects are mutually supporting in both the metaphysical and therapeutic project of constituting a rich moral self, that is, a self who has self-trust and thereby satisfying relationships with others.

I also register a slight disagreement with Potter concerning the effect that bipolar illness has on agency. Potter claims that with conventional narratives patients have difficulty perceiving themselves as agents—at least in excessive manic or depressive phases. I argue, however, that conventional narratives do not make it difficult for bipolar patients to see themselves as agents, but rather makes it difficult for them to see themselves as consistent agents.¹

Conventional Narrative Selves and Self-Trust

Potter makes clear that self-trust is crucial to living a flourishing life. Although Potter does not clarify precisely what she means by a ‘flourishing life’ within her argument, one could surmise that at least she means satisfying relationships with others, for example, trusting, reciprocal, affective, and cooperative relations. Self-trust, Potter clarifies, enables us to confidently undertake tasks, fulfill obligations, and plot future goals. Thus, self-trust is a necessary feature of satisfying relationships.
with others because it enables us to believe we can be counted on by others.

Bipolar patients, Potter claims, do not appropriately develop self-trust. In manic states, patients may trust themselves too much at the cost of valuable critical reflection on one’s projects and desires. In depressive states, on the other hand, patients do not trust themselves to be capable of carrying out projects, including, perhaps being a good friend. The oscillating and contradictory experiences of self-trust for the bipolar patient, therefore, undermine a sense that she is one, coherent self with persisting goals or values.

A coherent self—which is one of the logical properties Potter enumerates of self-trust—is a conventional narrative self (NS).2 Minimally, a NS is a self that experiences—most likely implicitly—past actions and values as impacting one’s current situation and are helpful both for framing and predicting one’s future actions and values. In other words, a basic feature of a NS is that she experiences herself as linear, that is, moves through time in a linear fashion. Second, a NS is also a self who recognizes himself as an agent, namely, a self that chooses, acts, and, more important, is accountable to both. A narrative that portrays me as an agent is one in which I can make explicit, at least in specific cases, why I undertook past actions or how those past actions bear upon my current situation (perhaps to explain ‘reportable events,’ i.e., bizarre, uncharacteristic, or irresponsible events). Third, a NS is one who does not feel alienated from, but identifies (appropriates as part of one’s story) with, past actions and values that shape one’s present sense of self. Alienation is an effect of not being able to see past or present actions as congruent with one’s values.

Although all three criteria play an important role in Potter’s understanding of a NS, I submit that the third criterion should be weighted more heavily.3 In fact, it is precisely because bipolar disorder tends to alienate the sufferer from past actions that continue to shape his future sense of self that a conventional (i.e., linear) narrative is so devastating for a bipolar patient. Potter argues that in conventional narratives: “[patients] cannot see their goals and actions as a reflection of their agency” (2013, 60). However, I have enumerated these three criteria to suggest that a NS is devastating and shaming to a patient, not because they cannot see themselves as agents, but rather as consistent agents. They are accountable to past actions, but they feel alienated from them.

To further illustrate why I disagree with Potter that conventional narratives deny agency to bipolar patients, I borrow an example from Marya Schechtman (2007, 170): imagine that some months ago I bought a sports car, but now I don’t really like this car, I don’t see it as emblematic of my taste in cars nor reflective of my personality. Although I no longer identify with this purchase, I nonetheless still recognize my obligation to continue paying the loan. Hence, this example illustrates that I can be accountable to a past action and choice (purchasing a sports car), and I can see how it impacts my present situation (obligated to pay car loan), even if I don’t identify with the person who bought a sports car. The fact that I don’t identify with this person means I feel alienated from past actions and values. And, it is this sense of alienation that makes conventional narrative theories devastating for bipolar patients.

**HOW NOT to BECOME UNHINGED**

Because a bipolar self is not a NS, Potter proposes another sort of narrative—the HN—that is adequate enough for a clinician to help a patient begin to cultivate self-trust. Self-trust requires that one take oneself as an object. To take oneself as an object, one must be able to conceive of oneself as having integrity. Narrative theories consider selves with integrity to be selves that are coherent, that is, internally consistent. However, bipolar patients oscillate between mood states that, at times, Potter shows, shade one’s goals and values in inconsistent ways. So, wholeness has to be imagined differently than a coherent narrative; thus the HN. With the HN, the bipolar patient, in collaboration with a trustworthy clinician, begins to attach a hinge between his oscillating states, tethering them together, not in a conventional linear way, but as a creative zone within which one oscillates. Potter further specifies that the patient, in collaboration with her clinician, needs to maintain a certain degree of sweep between mood states—a degree that
protects the patient from becoming too unhinged to conceive of herself as whole, and from thereby being unable to sustain satisfying relationships with others.

I agree with Potter that a new narrative form is promising for bipolar patients because it doesn’t require them to order the important events that continue to shape their present selves as an unfolding and deepening of one’s character. The NS presumes that a cluster of traits persists through time and that one’s identity is best understood in terms of those consistent traits. Hence, this narrative form will have no other way to make sense of the contradictory (i.e., inconsistent) activities and values of bipolar patients. And, if the narrative form doesn’t posit the bipolar self as an object with integrity, then bipolar patients are unable to satisfy two of the important logical conditions of self-trust: (a) taking oneself as an object and (b) taking oneself to have characteristics that consistently persist across time.

With the HN, bipolar patients can imagine themselves as whole persons constructed out of oscillating states that are constrained within a certain manageable sweep (the manic states are not too manic, the depressive states are not too crippling) so that the patient can maintain better relationships with others. The HN demands some amending of the logical properties of self-trust that Potter enumerates, that is, (a) objects are orbital maps of oscillating mood states and (b) continuity through time is identified not by a consistent cluster of traits, but rather the orbital pattern of the hinge zone (the constrained sweep between manic and depressive states). Friends and loved ones can come to accept the oscillating states—assuming they are well managed—as the distinctive narrative logic of a bipolar self. And, more important, the bipolar patient begins to construct a narrative that does not shame—this is due to the fact that it doesn’t impose a linear logic that at times could alienate her from past actions that continue to shape present circumstances (e.g., buying a sports car).

The more important feature of a HN for Potter’s argument is that it anchors the patient well enough to build self-trust. Remember, for Potter, self-trust is crucial for a flourishing life. And, a flourishing life is one in which I build satisfying relationships with others. When I trust myself, I become the kind of person that others can count on because I also count on myself to act with good judgment (consistent agency). And, in addition to being able to take myself as an object that has continued integrity—which the HN does—I need to figure out (a) in which domains of my life I trust myself to do something well and (b) I need to learn to better prioritize my goals through critical reflection. Potter’s argument suggests that (b) critical reflection and prioritizing of vital goals will crucially depend on relationships with trustworthy others, such as a clinician, who can help me to maintain a manageable sweep between mood states so that I do not undermine important relationships and vital goals. Therefore, I want to spend the remainder of this commentary reflecting on (a) how a bipolar patient can learn to trust himself in specific domains, for example, orienteering in the backwoods or constructing a course in the Philosophy of Mind. I now turn to a very brief discussion of work in feminist theories of embodiment as a promising resource for bolstering the HN as a means to cultivate self-trust in bipolar patients.

### Habitual Self

Before turning to a brief discussion of the habitual self in feminist phenomenological theories of embodiment, I want to make explicit an implicit connection in Potter’s argument between (a) domains in which the patient has self-trust and (b) domains in which the patient already has skill. In giving suggestions for how to cultivate self-trust, she writes:

> one therapeutic goal might be to identify positive domains of self-trust and explore why the patient can trust herself in these areas. Then, the clinician and patient could work toward expanding the domains of self-trust. (Potter 2013, 63)

What I want to highlight here is that the positive domains of self-trust (a) are (b) domains in which the patient has skill. Although skills become habitual, not all habits are skills. Habits are automatic, preconscious, predictable, coordinated, consistent activities. Skills are habits, but
distinctive from them because they are practiced abilities. Skills required a conscious intention to develop them and hours, weeks, or years of effort to master. Finally, all habits are a tacit form of self-knowledge or self-image.

Narrative theories of identity make explicit one’s self-conception, whereas feminist phenomenological accounts of the habitual body make explicit one’s self-image. A self-conception depends on language; a self-image does not. Our self-images guide action, but they do not become conscious in the way that our self-conceptions do. One’s self-image is a tacit form of self-knowledge, although it is capable of becoming partially explicit or narrated.

Elizabeth Grosz (1994) discusses self-image in terms of the neurologist Sir Henry Head’s work. Head postulated that we have a ‘postural schema,’ which is a unified, preconscious, three-dimensional image/representation of (a) our body in space, (b) its relationship to other objects and bodies, and (c) the properties of our bodies, such as the length of limbs (Grosz 1994, 65-67; cf. Alcoff 2007, 107). Postural schemas integrate tactile sensations with visual information and these schemas are not present to conscious awareness. For example, because I have a postural schema that registers my height, I automatically duck under a doorway that I cannot clear. Furthermore, our postural schemas are plastic: as we practice new postures, mannerisms, or tool usage, we automatically adjust our self-image in accordance with skills we develop. Young children learn how to use spoons and forks to feed themselves, women train themselves in accord with social practice to sit with crossed legs or to walk with shorter strides, and hockey players learn to flip the puck with their stick to skate toward the goal, all thanks to the postural schema and its adaptability to new postures and “practiced movements” (Alcoff 2007, 107). One need not direct conscious awareness to these activities to accomplish them, nor need one first make explicit to oneself what needs to be done to carry them out.

One’s self-image or postural schema is also bound up in what William James describes in The Principles of Psychology (1981) when he calls us “bundles of habits” (109). James describes:

We all of us have a definite routine manner of performing certain daily offices connected with the toilet, with the opening and shutting off of familiar cupboards, and the like. Our lower centres know the order of these movements and show their knowledge by their ‘surprise’ if the objects are altered so as to oblige the movement to be made a different way. But our higher thought-centres know hardly anything about the matter. Few men can tell off-hand which sock, shoe, or trousers-leg they put on first. They must first mentally rehearse the act; and even that is insufficient—the act must be performed. So of the questions, which valve of my double door opens first? Which way does my door swing? Etc. I cannot tell the answer; yet my hand never makes a mistake. No one can describe the order in which he brushes his hair or teeth; yet it is likely that the order is a pretty fixed one in all of us. (James 1981, 120)

Here, James stresses in his description of habit that we function as consistent, coordinated, unified, and goal-directed selves (with the aid of postural schemas) without narration or conceptualization of this pragmatic unity. One could, James points out, try to narrate the sequence of events, but one is likely to get it wrong and would do better to just perform the habitual activity. Although we do not narrate habitual movements, we can incorporate into our NS or HN the habits or skills we develop if others, such as a clinician, points them out to us.

Among the many reasons why phenomenological accounts of embodiment have been important to feminists is the insights into cultural patterns of meaning—especially oppressive cultural patterns—habitual bodies give (c.f. Alcoff 2007; Sullivan 2001). For example, women may shake hands less aggressively, or as Iris Marion Young famously shows, may not be able to throw a football with skill (Young 2005). However, my interest in proposing an alliance between feminist phenomenological accounts of embodiment and narrative theories of self here is to help clinicians to cultivate self-trust in bipolar patients rather than to critique cultural patterns of meaning.

Habitual bodies are bodies with certain recognizable skills that can supplement one of the important therapeutic aims of the HN: constituting a self with adequate unity or integrity. Although the habitual body of a bipolar patient may not have a habitual moral character, she may, for example, have a habit of recycling. Regardless of
mood state, she sorts out paper, plastic, glass, and other recyclable goods whenever she goes to throw things away. She may also have a skill of performing CPR, regardless of mood state, which others can benefit from or ask her to perform. Either of these skills might be a place to start building self-trust. Certainly, there will be some skills or habits disrupted by bipolar illness and part of the therapeutic process will be sorting out those skills and habits that continue despite oscillating mood states and those that do not. Furthermore, if some of the skills that matter to a bipolar patient become disrupted during a depressive or manic state, then the clinician might want to use this information as part of the process of cultivating “a desire to avoid scenarios where certain vital goals would be threatened by worsenings of his illness” (Potter 2013, 63).

Although Potter’s argument demonstrates that bipolar selves cannot be coherent selves in one sense of the word, coherent, feminist phenomenological accounts of embodiment show another way in which bipolar selves can be coherent: they cohere in habitual bodies. This second sense of ‘coherent,’ however, needs to be further explained. The sort of coherence that embodied subjects possess on feminist phenomenological accounts should not be confused with a type of coherence that traditional physical-continuity theorists posit. The sort of embodiment that physical-continuity theorists point to in debates over personal identity is merely a body as object in space, not a habitual body or a postural body.

**CONCLUSION**

I have discussed the habitual body, which is the object of investigation of feminist phenomenological theories of embodiment, to identify another resource for clinicians interested in taking up Nancy Potter’s HN in work with bipolar patients. By pointing out to bipolar patients the skills they retain despite oscillating mood states, clinicians can further bolster the work of the HN in cultivating self-trust.

**NOTES**

1. I imagine that here too Potter will see this as a friendly amendment.
2. Potter does not directly claim that a coherent self is a conventional (viz., linear) self; however, her clarification that to be capable of self-trust “assumes continuity of self across time and that the subject can recognize the outcomes of her actions, as well as the desires, aims, and judgments underpinning those actions, as stemming from her” (58) does map onto linear theories of the NS (e.g., Schechtman 1996).
3. I am not reproducing the criteria Potter enumerates to describe a NS because I want to emphasize the feature of a NS that devastates bipolar patients. My third criterion—one does not feel alienated from past actions and values—is implicit in Potter’s argument, for example: “[s]o the values the patient holds, and the moral landscape she takes herself to be moving within, changes depending upon mood states. The bipolar patient may feel she has a moral compass with no magnetic north, so to speak. Does she value fidelity in relationships? Gentleness in disputes? Financial security and responsibility? It depends on whether she is manic, depressed, or in remission” (Potter 2013, 59).
4. For the purposes of this argument, I am calling recycling a skill because it first required a conscious intention to develop as a habit.

**REFERENCES**


