New Trends in Philosophy of Psychiatry

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1.1. Introduction

New trends in philosophy of psychiatry get along with critics of objectivistic paradigm in mental disorder conceptualisation. The main problem that philosophy of psychiatry tries to resolve is how to set the norms for the criteria of mental disorder definition. The major concern of the problem is to differentiate whether the nature of the norms are medical or social. It's very important to take a look into the contemporary debates of the matter because the knowledge of the field is crucial in taking direction and applying methods of psychotherapy approaches.

1.2.The mental disorder concept

The basic problems that philosophy of psychiatry is dealing with, are criteria, norms to define a mental disorder concept. *International Classification of Mental and Behavioural Disorders*[1] and *Diagnostic and Statistical Manual of Mental Disorders* (DSM V), are two manuals in the standard use for the description, classification and diagnosis of mental disorders, as well as bihevioral disorders. These manuals do not differ in the important entries, so when disscusing classification of mental disorders it applies to both of them.

The range of descriptions of psychological conditions is diverse and it includes moods disorders, anxiety disorders, schizophrenia, psychotic disorders, adjusment disorders, somatoform disorders, dementias, childhood disorders, separation anxiety disorder, autism, personality disorders and so on. The description involves several hundreds disorders of various kinds and varieties. Diagnostic manuals are the accumulation of clinical experiences through the generations of clinicians and through diverse forms of giving help to patients.

Modern western psychiatry which contains contemporary concepts and categories of mental disorders originates from the end of 19th century and the beggining of the 20th century. Reliability of applying these categories is not present in each, particular case. Reliabilty did increase, at least in research settings, by removing from symptoms descriptions and disorders, the assumptions of underlying causes such as brain damage or unconscious psychodinamics. Formative influence in moving toward observational portrayal of symptoms not including implicit causal or any other theoretical explanation in psychiatric manual, started with Carl Hempel on the psychiatric conference in New York in 1959.[2] Hempel made a great contribution to the reliability of diagnosing, by using the terms of description of symptoms, as much as

[1] This manual is the part of *International Classification of Diseases and Related Health Problems* (ICD) which is created by World Health Organisation

[2] Bolton, 2008., p. 3.

possible, in the array of observed, and by specifying symptoms, or the combination of symptoms that were necessary for a diagnose.

But still, the problem today is the status of the norms on which the observer count upon in deciding whether something is or is not a disorder. From this problem stems the question put by philosophers of psychiatry, whether these norms are objective, medical facts or they are actually social norms?

In physical medicine diagnosis are linked to the implication what is the cause of a certain disease such as bacteria, viruses, lesion, tumor etc. It is clear that some diseases can be caused by a specific factor but with psychiatric states that is not the case. The causes of pychiatric disorders are complex, involving factors such as genetics, developmental neurobiology, early experiences, social context, personal attitudes, life circumstances etc. In clinical, limited conditions it is not possible to establish the causality. This is the reason for manuals to add one more condition for set a diagnose which is a connection of a symptom or a syndrome with life distress, problems in social or professional sphere or some other important sphere of life. This condition is important for exluding persons with certain symptoms (for example halucinations or compulsive behaviours) wich are not disturbed by it in ordinary life. These are the criteria for mental disorder in the manuals, but philosophy of psychiatry[3] is interested in the definition of the mental disorder concept that would be satisfactory.

The very concept of mental disorder has been introduced to escape bigger problems with the use of mental illness concept. In DSM-IV[4] mental disorder is conceptualized as:

> *„as clinically significant behavioral or psychological syndrome or pattern tht occurs in an individual and that is associated with present distress (e.g., a painfulsymptom) or disability (i.e, impairment in one or more important areas of unctioning) or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom. In addition this syndrome or pattern must not be merely expectable and culturally sanctioned response to a particular event, for example, the death of loved one. Whatever its original cause, it must currently be considered a manifestation of behavioral, psychological or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarly between*

[3] Idem.
[4] Idem, p. 6.

the individual and society are mental disorders unless the deviance or conflict is a symptom of a disfunction in the individual , as decribed above. ".[5]

The defintion as such qualify mental disorder as a personal dysfunction different of normal reactions on problems of life on one side, and different from social deviations on the other side.

The underlying problem in the conceptualization of the manuals is standardization of psychological functioning used in psychiatry as well as the relation between diagnostic reliabilty and validity. The very norms of psychological functioning are descripitve and observational, and whatsmore the problem is whether these norms are scientifically or socially determinated. The judgement of normality is always brought by a comparation with average referent group and it is not quite clear why would the deviation from normality be a disfunction and not just a difference. Scientific facts do not support the idea of a clear cut between mental disorder and mental normality. On the contrary, the sciences such as psychology and bihevioral genetics prove that a lot of psychiatric states are just a certain degree of a characheristic in general population. Even the authors of DSM are explicit about not existing assumption that each category of mental disorder is an entity per se with clear borders which would differentiated it from some other mental disorder or lack of a mental disorder. Furthermore, the whole project of manuals is based upon the assumption that mental states and behaviors could be rationally and realibly identified by psychiatrists as an objective fact. That assumption is far from a neutral position which objectivity demands. The agreement on identification of mental disorder is based upon an implicit theory which is again a matter of questioning whether it is founded in medicine, psychology or cultural tradition.

1.3.Possible explanations of mental disorder concept

There are several possible explanations of mental disorder concept[6]. The first approach says that mental disorder is a break of meaningful relations in a mental life. It means that there is no

[5] *American Psychiatric Association*, 1994., p. xxi-xxii.

[6] Bolton, 2008.

available object for an emotion, or there is an excessive emotion toward the object of that emotion, or there are believes which are not supported by experience and/or education; or behavior which is not under the voluntary control of a person or is not synchronized with personl aims and believes.

The second approach says that mental disorder is a result of structural and functional lesions in the correspodent neural processes.

The third approach to the explanation of mental disorder concept is that the mental disorder is a matter of underaverage functioning in relation to statistically normal functioning for human beings.

The fourth approach is based on the notion that in mental disorder, mind does not function as it were designed throught the process of evolution.

The problem with all of these approaches is that they demand much wider perspective and facts than it is possible to gain in clinical conditions. Even more, some of the criteria such as meaningful relations or loss of meaningful relations depend on subjective view and interpretations of a clinician. Comparision with statistical «normality» raises a question about the reference group and whether a comparision with some other group would give the same results. The same problem is with the approach that is based on design made by evolution as a criteria for mental disorder, because, neither lesions nor functioning designed by evolution can be proved in clinical conditions. In short, we could diagnose «nondisorders» as disorders. For each of these approaches there is a version in which is not possible to distinguish disorder from «nondisorder» in clinical conditions:

(i) When we understand the context in which some break of meaning have occured, the wordlwiev of a person, life experiences and events, subcultural norms, the meaning and the significance of certain behavior becomes obvious.

(ii) Although there could be a lesion that causes some mental problems, the psychological processes could also make quite similar mental disturbances and seem as caused by neurological lesions.

(iii) Problematic functioning can deviate from statistical norm of a certain referential group, but not from some other referential group with similar characteristics. ne od druge referentne grupe sa sličnim karakteristikama.

(iv) There is not a single mental mechanism that functions unless it was not designed by evolution, but problematic functioning develops in the chaos between evolutionary design and current enviroment.

The contoroversies that derive from the critic of mental disorder concept raise a question whether we can speak about the mental disorder at all, if the states we find in psychiatry are the reactions on some extraordinary events? In such a case these states are not disorders, but quite opposite meaningful states and an effort to introduce some order. The very name «mental disorder» implies problems.

However, if the norms to define mental disorder are social, then they are not medical and medical model becomes unsuitable for psychiatry. These controversies are especially significant for determinating a relation toward patients and for the treatment they will get. If psychiatric states are not mental disorders then psychological and social approaches which demand psychotherapy instead of medicalisation, associations of persons with psychiatric problems, changes in social organisation, and acceptance of diversity of human experiences are the correct answer to these problems.[7]

1.4. The critic of the mental disorder concept

Dominant critiques of mental disorder concept are psychological, evolutionary and sociological theories of mental disorder concept.

Psychological theory of mental disorder concept is based on psychology which as a science has a tendency to «normalise» mental states as opposed to psychiatry which has a tendency to «pathologise» them. Psychology is a science of mental functioning and behavior and psychology tries to understand these behaviors in various ways. One way is a statistical approach which understands every variety in behavior as a part of total range of behaviors. It means that if we take any characteristic, the majority of population possess some average value, and very few people are on the extremes of the distributive curve. For example if we take in the

[7] The example for this is excluding the homosexuality from DSM III manual in early seventies in last century. Today we have to deal wuth a question whether are children with more temperament diagnosed as ADHD which would mean that their behavior is patologized. The same is th case with older people with mental capacities decline which is quite normal for the age and they get medication for it. ranih sedamdesetih godina prošloga stoljeća govori tomu u prilog.

account inteligence, the majority of population possess average inteligence, and very few possess very low or very high inteligence. In that way we can understand when somebody is extremely sociable and has a wide range of people in her social circle, always surrounded with people, crowd and likes noise or, on the other pole, somebody who is extremely unsociable, without a close friend and feels uncomfortable in the presence of people. Psychology doesn't consider it as a deviation from the normal sociability, it is just on the extreme ends of a distribution curve. It doesn't mean that it is illness or disorder and that it has to be cured. In such a case we just try to understand these behaviors.[8] The psychological approach to normality has very important implications for the shift in concieving a mental disorder. Mental disorder is mental abnormality, and abnormality carries normative and evaluative weight by implying that mind does not function as it is supposed to. Moreover disorder and abnormality conotes rarity of appereance in general population. The third implication presuposses that normality/abnormality is a dichotomy and that somebody is mentally disturbed or he or she is healthy. The forth implication is that the persons which gives the atributes normal and abnormal to some behavior pressuposse for themselves to be mentally normal, so that normality carries a connotation of belonging to a certain community of mentally normal people, while mentally abnormal persons are outside of the community. Psychological approach undermines the mental disorder concept, because statistical rarity is more or less arbitrary characteristic and normality is not a binar category. Psychological models of mental functioning, and related therapeutic approaches seek the meaning in the apparent senseless emotional reactions so that something which, in the beggining, seemed abnormal eventually appears, normal. Some «mental disorder» symptoms can be sensible attempts to solve a problem. Psychological theory of mental health is abudant with such examples.[9] In general, psychological model of psychopathology focuses on normal functioning and understanding of unadequate emotions taking in the account the context of the person, and understands syptoms as strategies for problem solving.

The evolutionary perspective[10] of mental disorder concept offers several explanations for the concept. According to the evolutionary theory mental disorder concept can be defined in following ways:

[8] Bolton, 2008., cites the statistical fact that 25 % of population, at least one in a lifetime, sufferred from the great depressive epizode. If so, then this experience can not be considered in the extreme. On the contrary, it is normal human behavior.

[9] The good example is occurance of panic attacks after some traumatic experience in the conditions recognized as the same or the simillar to the conditions of the original traumatic experience, for example the fear of driving after a car accident as a protection of a possible danger.

[10] Cosmides and Toby, 1999., Richters and Hinshaw, 1999., according to Bolton, 2008.

(i) Defensive/coping strategies

«Evolutionary theory emphasizes adaptation and survival, and much of the biological resources of the living being are designed to survive adversity, whether this be in the external enviroment or the internal…» [11] Living beings use the strategies of coping and defense and when there is a psychological disfunction caused by a damage of neurological structures, a living being will try to compensate and the behavior which it manifests is a strategy for coping the disfunction.[12]

(ii) Strategies that involve disruption of function

The loss of a function may be sacrified because of a need on a higher hierarchical level for surviving. That is the way that something that seems to be a disorder, is in fact, the order.[13]

(iii) Design/enviroment mismatches

The behavior is designed to gain some results in a certain enviroment, and disfunctional behavior may appear in the transfer to the different enviroment. In evolutionary context, disfunctional behavior may arise in the mismatches between evolutionary design and current enviroment, if the enviroment is different in significant determinants for the design of the behavior. The example a child is growing up in emotionally and intelectually nonstimulative enviroment which can result in a lack of empathy in the adult.

(iv) Phenotypes that look maladaptive but may be adaptive

Evolutionary theory says that maladaptive behaviors are not selected, and if some behaviors are persistent then they are connected with some adaptive function. Regarding the fact that mental disorders endure we can conclude that they have some adaptive function. So, from evolutionary perspective, mental disorders are not disorders at all.

(v) Highly evolved learning capacitis leading to maldaptive behavior

[11] Bolton, 2008., p. 78

[12] Contemporary models of autism and schizophrenia follow such an explanation, supposing that behaviors characteristic for such disorders are adaptive in their nature.

[13] Malatesti, Jurjako, 2016., say that some authors concieve that psychopathy is evolutionary adaptive surviving strategy which disqualifies it as the mental disorder.

In generaly we are evolutionary designed to learn, but we can employ these abilities to reach also some disfunctional behavior. The common case is the transfer of learnt patterns of behavior from the original enviroment to some unadequate enviroment.

Form the evolutionary perspective a lot of symptoms are probably coping strategies for survival in an unknown or stresfull enviroment and some states which are classified as mental disorders can be adaptive in some other enviroment.

Sociological critiques of mental disorder concept dates from the last century. In 60-ties psychiatric approaches to the mental disorder were openly critic and even hostile toward the concept. Critiques ranged from the idea that modern society took away the meaning to the madness, which is the tendency of medical model in psychiatry which patologize the meaning in the madness, and has the simillar tendency to patologize ordinary everyday problems, to the idea of political function of psychiatry as a mean of a control of social deviations.

The main critiques were made by Laing[14] and Szasz[15]. Sociological critiques of psychiatry are various, but they all agree that psychiatry determines some states as disorders according to social values, using categories of psychopathology to disqulifiy and control the threat to social structures of power.[16] Sociological critiques of psychiatry revealed social context and social dynamics of psychiatry, by showing that psychiatry as any other discursive practice is embeded in social structures of power and is the subject to their influence. The problem with such an approach is that it is not individual and doesn't take into the account the suffering of the individual person.

Anti-psychiatry of the 60-ties of the last century, which used to attack medical model of psychiatry, raised very important question which brought disccusions if the mental disorder concept is based upon natural facts or is it completely the matter of social norms and values. Anit-psychiatry was «accusing» psychiatry of shifting social norms with medical, and therefore taking away the meaning from the mental illness, disqualifying illness and the persons who were diagnosed. This is the way to label any behavior as a disorder in the accordance to the current state in a society or in accordance to social power. So, psychiatry became a tool for sociopolitical misuses. Under the pressure of the anti-psychiatry critiques the term mental illness was replaced by the term mental disorder, without clarifiying and determining the

[14] Laing, 1960.
[15] Szasz, 1960.
[16] Bolton, 2008., gives an example of the mental concept use for social control in mid19th century, by diagnosing slaves who tried to escape with a diagnose of «drapetomania».

concept. The main challenge for psychiatry was to show that dignostic practice is based on objective, natural facts, not only on social norms and values.

1.5. New paradigm of mental disorder

The new pardigm which is being formed in the theory of mental disorder finds its strong hold in genetics and psychology. Methodology in genetics brings much more complexity and subtle connections. Psychology, especially with an accent on learning as a part of creation of a behavior, is sensible to individual differences that occur from different learning histories. Pychology, in combination with genetics, is able to recognize how learning history and genetic differencies are a source of individual variations. In the new paradigm of biopsychosocial science these explanations are interwined and keep in sight social, subcultural, family and personal level. The latest research on the matter talks about mutual interaction of genes and enviroment. It is generaly accepted that enviromental factors influence genes in the brain development and maturing. Th variations in behavior are the reflection of the mutual interacting of genes and enviroment, as well as social enviroment and the very process of socialization. Genetic, evolutionary and psychological paradigm interupts with idea of psychological phenotypes which are determinated only with natural factors and with idea od the natural-social dichotomy.

Several authors have been trying to reveal what is it «a natural fact» , the core of mental disorder debate. The most influential among these authors are Christopher Boorse and Jerome Wakefield[17]. Their suggestions are characterized as the form of naturalism. both authors presupossed that the mental disorder concept involves scientific, objective, natural norms as well as social norms. The task was to deteriminate precisely what is psychological disfunction when social norms and values are extracted. Boorse considers that natural fact in the foundation of mental disorder is the matter of statistical abnormality[18]. Normal functioning of some psychological or biological organisms is solely the matter of usual function of the mechanism, and disfunction is a deviation from statistical norm. There are several problems with statistical definition. One of them is how to differentiate a disfunction from a disorder. It is not clear why would different functioning, if not causing any harm, be disfunctional at all. The next problem is that the difference from a norm is usually a matter of continuity, and not category, especially concerning characteristics that are normally distributed. The point in which a difference

[17] Malatesti and Jurjako, 2016.
[18] Idem, p. 177.

becomes a dysfunction is arbitrary form the ststistical point of view, so the concept of dysfunction is not enough for determining pathology. The benefits for an individual and her natural functioning should not necessary overlap.[19] Furthermore, there is also a problem of relativity of all the questions of statistical deviations in the population, because of the huge interpersonal diferences in the enviromental features and mutual relationship between individuals and their enviroment. It brings to the relativity in the judgement of statistical normality and deviation from which there is no escape. In the practice it makes a significant influence on the judgement of psychological normality and in that way it shapes social experience, values and expectations.

Wakefield in his theory of mental illness takes into account evolutionary design of mental functioning and behavior. For him, the correct functioning is the matter of the purpose for which the mechanism has been designed through evolution, and a dysfunction is a deviation of the designed function. Wakefield's evolutionary naturalism states that an important criterium for the mental illness, is the harm that is inflicted on the person according to standards of the culture in which that person lives. The harm brings about the condition in which the mechanism is not able to perform its natural function. Wakefield considers a natural function to be a result of the evolution of the mechanism structure[20]. Evolutionary naturalism shows if a diagnose is valid, then it can not be descriptive. If we accept evolutionary naturalism, the reliability of a diagosis is unsustainable. In such a case we would need a scientific program in evolutionary psychology and psychiatry in order to differentiate genuine mental disorders with a disfunction in evolutionary design, from mental disorders that just seem like that but do not include an error in a mechanism of the evolutionary nature, such as stress related conditions. This difference between genuine disorders and disorders that just seem to be like it, has no practical use and is just an abstract theory.

Both authors, intorduce a concept of social norms as crucial for determining concept of mental disorder and both try to define the foundation of natural, non social, medical disfunctions. The elaboration of Boorse's and Wakefield's ideas brought the recognition of difficulties in applying naturalism in this field and that is why naturalism didn't succeed and by that opened a field of social questions that are in the interaction with psychiatric diagnosis and practice. «Natural» is difficult to distinguish from «social» on this level of science. Natural means evolved, genetically inheritade, but evolution and influence of genetic inheritance on

[19] Cooper, 2002., 2007., according to Malatesti and Jurjako, 2016., p. 181.
[20] Idem, p. 183.

social behavior, too. There are also individual variations and each phenotype is a result of interrelationship between genetic and enviromental factors. Bolton says: *„what is natural in sense of evolved is one factor involved in the production od individual and social behaviour , it is not a third factor.*"[21] In psychological functioning we cannot divide this and it is possible that distinguishing between natural/social functions better in fisiology and in general medicine.

If we try to conceptualise mental disorder without naturalistic definitions, the general conclusion is that the main features of mental disorder are, in that case, harm, suffering, pain and the response of health care on that sufferings.[22] One of the attempt is to define mental disorder as a break down of a meaningful relationships. It is crucial to say that this kind of break down is painfull and causes suffering.[23] Psychological approaches of the last century and nowdays are finding out a meaning even where there is none. Psychological etiological models of psychiatric conditions imply the processes of learning which happened to be in difficult situations in order to satisfy needs. It caused those processes of learning to become abnormal, because they occured in unusual situations and even extreme conditions. That's why these processes of learning involved distorsions and emptiness. Such explanations support the idea that maladaptive, disfunctional behavior may evolve from untoward experiences, and learnings that folow from it are learnings about how to manage in these circumstances. The whole process is understandable in the context in which it occurs. Although it could be understandable in that context, the behavior is disfunctional in relation to person's needs and values and to relation to our perception of these needs and that is what determines mental disorder. This brings us to the possibility of defining mental disorder as a concept which involves maladaptive meanings. «*That said, psychological clinical science has not been entangled in defining and deciding truth and falsity, correctness or error, in mental processes, but has rather settled on the term maladaptive to put the emphasis on the outcome of mental processing- tha fact that it brings about harm, and specifically, more harm then good*.»[24] According to psychological models, a lot of conditions in psychiatric manuals include some degree of meaningful processing, no matter if they are the results of lesions in the same time.

[21] Bolton, 2008., p.181.
[22] The manuals such as DSM takes into account the problems people come with to clinic, but it doesn't explain whether are in these problems involved also everyday problems or socially defined problems.
[23] Foucault, defined madness as a lack of rationality and meaning. Bolton, 2008., pr. 183.
[24] Bolton, 2008., p. 189.

Good example for this are delusions, which are taken to be symptoms of psychiatric disorder, and which can be explained variously, as a result of a social indoctrinaction[25], or a reaction to some experince and as a attempt to give a meaning to some extreme experience. The example is a belief which could seems to be rational, and becomes irrational when we take into account cultural contex in which person grew up and in which lives. So we could say that in each human experience is some degree of meaning and rationality. To define mental disorder just as a lack of meaning is too strong demand, because most of the conditions from psychiatric manuals would be excluded [26].

1.6. The Hermeneutical Stance

Mental disorder in its very name implies that there is some order and the assumption that the order could be distinguished from the disorder. This assumption doesn't arise from the psychiatry, but from the culture in which psychiatry is inbeded. So the idea that absolut natural order exists in the way of complete freedom of social norms, values and understanding is simply impossible. Researches of history and epistemology of psychiatry[27] suggest that psychiatry is in crises because it relies on the implicit theoretical assumption that DSM is atheoretical and that mental symptoms are observed on a pure descriptive level. Cambridge school[28] represents the notion that «diagnosing» is not a process which goes from the bottom to the top of the apstraction, i.e. from the description of the symptom to the conclusion of a diagnosis, by applying impersonal operational diagnostic criteria. On the contrary, «diagnosing» relies on the hermenutical circle where the parts, mental symptoms, and the whole, psychiatric diagnosis, are interrealted.[29] It means that diagnosing by the principle of the verification patient's simptoms and the composition of the picture which responds to a certain diagnostic category described in DSM is not a right approach for the psychiatry. According to these scientists, a diagnosis is a product of a dialoge between psychiatrists and the patient, and is not outside of their relationship.

The hermeneutaical stance is founded on the idea that mental simptoms are not the facts, i.e. the objects which are simple «data» and they are not to be described as such. Mental simptoms is a mutual construction in therapeutic relationship.

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[25] Glover, 2014., distingushes delusions for which the cure is an argument such as in Richarda Dawkins' book „The God Illusion “ and delusions which could be a rational response to unusual experiences.
[26] Bolton, 2008.
[27] Aragona, 2013.
[28] Berrios, 2013., 2014., the common name for several history and epistemology of psychiatry scientists.
[29] Aragona, 2013.

The subjective utterances about a bad mood, or some understanding or about voice hearing are by a definition mental states which a person is aware of, and is made on the ground of the interpretation of the inner experience. Regardless of the cause, a spontaneous brain activity, a brain desease, stresses in everyday living, traumatic experiences, or the combination of all o fit, there must be some change which a person becomes aware of. Introspective reports bring with them several difficulties, theoretical/epistemological as well as practical. In order to be able to say something about the experience a subject has to be able to identify it, distinguish it and name it

This first experience Cambridge school calls, „primordial soup". „Primordial soup" is prelinguistic and preconceptual experience which a patient experiences through the raw directness. The subject is aware that something happened inside her, but in this phase it is a protoexperience. From this experience to the «subjective mental simptom» it has to pass throug several phases of interpretative activity.

In the first phase the factors for deciding the development of primordial soup of experiences are the context in which the change of experience occurs and the quality of the change (for example the change in experience may be faster or slower, take more or less memories, or be similar to something already experienced or be completely unknown etc.) These factors are playing a crucial role in the configuration of the very experience.

In the second phase the factors that concern a personal and sociocultural context are crucial for the configuration of changes which a subject experiences in her consciousness. This is the first hermeneutical step, i.e. the selfinterpretation of a patient's own experience which takes a form through personal, family, social and cultural styles of shaping and naming the experience. For example, here are the crucial factors: the previous experience, personal traits, education, inluence of the media, use of language etc. In that way the tendency for introspection can generate more detailed description of someone's experience, the level of education may set the dictionary which a person chooses to describe the experience, the culture may be encouraging or discouraging for the emotionality and can bring to «cognitivet» or «somatic» description of the experinece and so on.[30]

The third phase is the second hermeneutical step and it includes the influences of the interaction which is crucial for the configuration of the change in the experinece into so called

[30] Glover, 2014., p. 119., says that lot of thinkers stressed that human is selfinterpreted animal.

«mental symptom». The crucial role in this phase is the encounter with a psychotherapist who can influence the formation of a certain symptom. It means that when it is difficult for a person to find a meaning in an experience, a therapist has a hugh influence on the formation of that experience by a direct suggestion or through the proces of construction. This is especially important in the moment when conversation can be helpfull to a subject to explain her experience. Of course, it is the very moment when psychiatrist or psychotherapist can act therapeutically to help a patient to understand her complex and unusual experience in some acceptable way. But a psychiatrist or a psychotherapist can also put in the conversation his prejudices which become the part of the final version that we call a mental symptom. A mental simptom is a complex construction.

That's why diagnosing is never a neutral description, but active common contruction of mental pathology. From the same reason a mental symptom that was cristalyzed is not a pure «object» but a complex product of interplay of several factors.

To recognize this impossibility to define mental disorder in apsolute terms and outside understanding andthe culture in which it evolved, means to think of a mental disorder concept as a hypothesis that is worth of future research. In this moment it means to be engaged in evergoing dialogue about the meanings and understandings of mental disorder and to define psychiatry as a discursive activity, which is not outside the culture and the society in which it has been practiced. This also applies to psychotherapy as a discursive activity and explains why it is justifiable to engage in the development and reasearch of hermeneutic appoaches to psychotherapy.

1.7. Implications for psychotherapy

Already mentioned epistemologic reasearches in psychiatry[31] show that mental symptoms and psychiatric diagnose are in the mutual relationship and are the construct made in therapeutic encounter.[32] According to the authors, clinician may take a crucial part in articulation of symptoms, especially when it is difficult for a subject alone to find some sense in the experience. It happens throughout heremenutical process, by engaging mutual influences that are responsible for the configuration of the patient's experience in to «mental symptom». A clinician is talking to a patient and setting working hypothesis which could be an input of clinician's prejudices that define the final version of patient's mental symptom. As it has been

[31] Aragona, 2013.
[32] Berrios, 2013., 2014.

said before several times, a clinican's position can never be a neutral one. In the same manner, a description during the process of diagnosing is never neutral either. On the contrary, a description is an active component in the creation of mental pathology. Mental symptoms are interpersonal constructs:

„They are constructs in the sense that subjects construct a meaning out of rather inchoate pre-linguistic experiences. They are personal because the experience is lived as unique or personal to the individual, and is accessible to others only indirectly and hermeneutically. They are interpersonal in that they are both a) strongly influenced by social and cultural factors, which help to shape the specific way in which the subject makes sense and articulates the experience, and b) co-constructed together with the clinicians and/or other persons that talking with the patient assist and influence her in shaping and naming the experience. Mental symptoms can thus be viewed as elaborated by patients and co-elaborated with others, particularly with psychiatrists in the context of a clinical setting.“ [33]

From the text above it is clear that dignosing as a hermenutical process can act *pro* and *contra* therapeutically. To shape an experience and name it can be a therapeutic procedure, if the experience becomes the part of meaningful life for a patient, or *vice versa*, it can be contra therapeutic if is dignosed from the position of «neutrality» and disqualifying it as sensless and ill.

The described influences that occur in psychotherapeutical communicational act are realized throught subtle and primarly unconscious process without explicit awarnes of the both sides. Psichotherapist's theoretical orientation, her knowledge about non/curability of a certain psychopatological category which a patient was labeled, the expectations that a therapist has from a patient in psychotherapy and her stereotyes toward certain classes of people, act as a powerfull prejudice which dictate the course and the result of a psychotherapeutic process.

The knowledge of my psychotherapeutic orientation, my attitude toward curability and expectations for pschotherapy to be succesfull are in the very core of the psychotherapy and it becomes my ethical and epistemic responsibility.

Conclusion:

[33] Aragona, Markova, 2015., p. 609.

The contemporary debates in philosophy of psychiatry show that a mental disorder concept is socially determinated. That is the reason why it is justified to develop psychological approaches in the treatment of mental disordered persons, especially the hermenutiacl psychotherapy approaches which are founded on the view that mental disorder is created in communicational act between a clinician and a patient.

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