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Psychotherapist's epistemic responsibility

Psihoterapevtova epistemološka odgovornost

POVZETEK

Sodobne razprave v okviru filozofije psihiatrije kažejo, da je koncept duševne motnje družbeno determiniran. To je spodbudilo nadaljevanje dialoga o različnih možnih interpretacijah duševnih motenj in redefinicijo psihiatrije kot diskurzivne aktivnosti, ki je občutljiva za vpliv kulture in družbe, v kateri se odvija. Isto velja za psihoterapijo kot diskurzivno aktivnost in opravičuje stalni razvoj hermenevtičnih pristopov psihoterapiji. Ti temeljijo na predpostavki, da se duševna motnja konstruira v komunikaciji med psihiatri (psihoterapevti) in njihovimi pacienti.

Glede na to, da epistemološka asimetrija, ki je v odnosu med terapevtom in njegovim klientom inherentna, daje prednost terapevtu, kar je razvidno iz številnih primerov, je psihoterapevt dolžan pristopiti h klientu na epistemološko odgovoren in empirično ustrezen način. To zahteva občutljivost za dokaze, v smislu zdravega skepticizma do znanstvenih temeljev koncepta duševnih motenj in psihoterapevtskih teorij, kot tudi kritične refleksije do lastnih teoretičnih predpostavk in predsodkov.

KLJUČNE BESEDE

duševna motnja, diagnostika, psihiatrija, psihoterapija, hermenevtika, epistemologija, odgovornost

SHORT ABSTRACT

Recent debates in the philosophy of psychiatry show that the concept of a mental disorder concept is socially determined, encouraging further engagement in a continuous dialogue about various possible interpretations of mental disorders and a redefinition of psychiatry as a discursive activity susceptible to the influence of the culture and the society in which it is practiced. This also applies to psychotherapy as a discursive activity and justifies the ongoing development of hermeneutic approaches to psychotherapy. These are founded on the view that a mental disorder is constructed within the communicational act between a clinician and their patient.

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Given that the epistemic asymmetry inherent in the relationship of a therapist and their client favours the therapist, as shown by numerous examples, the psychotherapist is obliged to approach the client in an epistemically responsible and empirically adequate manner. This requires sensitivity to the evidence, understood as healthy scepticism towards the scientific foundations of the concept of mental disorders and psychotherapeutic theories, as well as critical reflexion upon their own theoretical presuppositions and prejudices..

KEY WORDS

mental disorder, diagnostics, psychiatry, psychotherapy, hermeneutics, epistemology, responsibility

Introduction

My interest for epistemological and hermeneutical approaches to psychiatry and psychotherapy evolved since 1985 when I joined the project School of Psychotherapy Cybernetics, which was organized in the frame of University Psychiatric Clinic Rebro in Zagreb (Medicine faculty) and led by Graham Barnes (Barnes, 1993; Možina, 1993). With colleagues from Ex-Yugoslavia we developed critical approach to the objectivistic epistemological stance in psychiatry and psychotherapy. Instead we proposed epistemology proposed by cybernetics (Bateson, 1972; Barnes, 1993; Miškulin, 2014), critical approach to psychopathology and »theoretical psychotherapy« (Barnes, 2002), »dialogotherapy« (Barnes, 2008), hermeneutic and constructivistic systemic psychotherapy (Možina and Kobal, 2005; Šugman Bohinc, 2005; Štajduhar, 2010; Možina, Štajduhar, Kačič and Šugman Bohinc, 2011; Miškulin, 2014), which is in accordance with postmodern trends in psychotherapy.

New trends in the philosophy of psychiatry are associated with the growing criticism of objectivistic conceptualisations of mental disorders. The main problem which the philosophy of psychiatry is striving to resolve, is the appropriate approach to determining the norms of defining mental disorders. It is essential to establish whether the norms ought to be of a medical or a social nature. The assumption that normality can be easily distinguished from disordered behaviour does not come from psychiatry itself, but from the culture in which psychiatry is imbedded. The hermeneutical stance is founded on the idea that mental symptoms are not facts, i.e. objects presented as simple »data«, and they should therefore not be described as such. Mental symptoms are mutual constructions created within a therapeutic relationship.

Moreover, numerous examples teach us that the outcome of a psychotherapeutic encounter is always a construct created within the relationship of the therapists and their clients. Given the epistemic inequality inherent in this relationship, psychotherapists are fully accountable for the nature of the therapeutic construct and the knowledge that they choose to implement in the encounter.

The concept of a mental disorder

The philosophy of psychiatry primarily deals with problematizing the criteria, or the norms of defining the concept of a mental disorder. The fifth chapter of the International Classification of Mental and Behavioural Disorders (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) are standardly used as manuals for describing, classifying and diagnosing both mental and behavioural disorders. As these manuals do not differ in the important entries, this article applies to both of them. Diagnostic manuals are formed by accumulating the clinical experiences of generations of clinicians and evaluating different approaches to helping patients.

The contemporary concepts and categories of mental disorders in Western psychiatry date from the end of the 19th and the beginning of the 20th century. The initial applications of these categories were mostly highly unreliable and lacked continuity. Reliability increased, at least in research settings, after the assumptions that brain damage or unconscious psychodynamics may be the underlying causes of symptoms had been removed from the formal descriptions of mental disorders. The formative influence in moving toward an observational portrayal of symptoms that excludes implications of causality, or other theoretical explanation in psychiatric manuals, started with Carl Hempel at the psychiatric conference in New York in 1959 (Bolton, 2008: 3). He significantly contributed to the reliability of future diagnoses by using terms that were as closely descriptive of the observed symptoms as possible, and by specifying the symptoms, or the combination of symptoms, that were necessary for a reliable diagnosis.

However, recent philosophical debates are still questioning the status of those norms in which the observer assesses whether something is or is not a disorder. This problem has encouraged philosophers of psychiatry to wonder whether these norms are objective, medical facts, or ought to be perceived as social norms.

Diagnoses in physical medicine are linked to ascertaining the cause of a certain disease, such as bacteria, viruses, lesions, tumours and like. While it is clear that some diseases can be caused by a specific factor, that is not the case with psychiatric states. The causes of psychiatric disorders are complex and involve factors such as genetics, developmental neurobiology, early experiences, social context, personal attitudes and life circumstances. It is not possible to fully ascertain the causality in limited clinical conditions. This was the reason why the manuals introduced an additional prerequisite for establishing a diagnosis – the connection of a symptom or a syndrome with observable personal distress in a social or professional sphere, or some other important aspect of life. This new requirement was necessary for excluding persons with certain symptoms (such as hallucinations or compulsive behaviours) which do not hamper their functioning in everyday life. While these are the formal criteria for diagnosing mental disorder, the philosophy of psychiatry is interested in producing a satisfactory definition of the concept of a mental disorder itself.

The concept of a mental disorder was introduced to avoid larger problems associated with the concept of a mental illness. In DSM-IV (American Psychiatric Association, 2001) a mental disorder is delineated as a:

»clinically significant behavioural or psychological syndrome or pattern that occurs

in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) 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 behavioural, psychological or biological dysfunction in the individual. Neither deviant behaviour (e.g. political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.«*(*American Psychiatric Association, 2001: xxi-xxii)

As such, this definition qualifies a mental disorder as a personal dysfunction that differs from normal reactions to the problems of life, but cannot be considered a social deviation.

The underlying problem in the way the manuals conceptualize mental disorders is the typical psychiatric standardization of psychological functioning, as well as the relation between diagnostic reliability and validity. The very norms of psychological functioning are descriptive and observational, and it is equally uncertain whether these norms are scientifically or socially determinated. The judgement of normality is always based on comparison with the referential average, although it is unclear why a deviation from normality ought to be a dysfunction rather than just a difference. Scientific facts do not support the idea of a clear distinction between a mental disorder and mental normality. On the contrary, sciences such as psychology and behavioural genetics have proven that numerous psychiatric states are, to a certain degree, just common characteristics within the general population. Even the authors of the DSM have explicitly rejected the assumption that each category of mental disorders is an autonomous entity with clear borders which can consistently differentiate it from some other mental disorder or lack of a mental disorder. Furthermore, the entire concept of the manuals is based on the assumption that mental states and behaviours could be rationally and reliably identified by psychiatrists as objective facts. This assumption is far from the neutral position required by scientific objectivity. The agreement on identifying a mental disorder is based upon an implicit theory whose foundations can be perceived as belonging to either medicine, psychology or cultural tradition.

Possible explanations of the concept of a mental disorder

There are several possible explanations of the concept of a mental disorder (Bolton, 2008):

1) Mental disorder is connected to a disruption of meaningful relations in a person's mental life. It means that there is no available object for an emotion, or there is an excessive emotion toward the object of that emotion, or there are beliefs unsupported by experience and/or education; or behaviour which is not under the voluntary control of a person or is not synchronized with personal aims and beliefs.
2) Mental disorder is a result of structural and functional lesions in the corresponding neural processes.
3) Mental disorder is a matter of under average functioning in relation to statistically

normal human functioning.

4) A mentally disordered mind does not function as it was designed through the process of evolution.

The problem with all of these explanations is that they demand a much wider perspective and a wider range of data than it is possible to acquire in clinical conditions. Furthermore, criteria such as »loss of meaningful relations« depend on the clinician's subjective view and interpretations. Comparisons with statistical »normality« necessarily entail questions about the control group and whether a comparison with some other group would produce the same results. The same problem occurs with the evolutionary explanation, as neither lesions nor evolutionally designed functioning can be proved in clinical conditions. It is therefore possible to diagnose »nondisorders« as disorders. Each of these explanations includes variations that cannot be distinguished in clinical conditions:

(i) Once we have understood the context in which some disruption of meaning has occurred, the worldview of a person, life experiences and events, subcultural norms, the meaning and the significance of certain behaviour become obvious.
(ii) Although there could be a lesion that causes a mental problem, similar mental problems can also be created without lesions, but only by psychological processes.
(iii) Problematic functioning may deviate from the statistical norm of a certain referential group, but not from some other referential group with similar characteristics.
(iv) There is not a single mental mechanism that functions unless it was designed by evolution, but problematic functioning develops in the complex interaction between evolutionary design and the current environment.

The controversies introduced by critics of the concept of a mental disorder raise the question of whether we can speak about mental disorders at all. Mental disorders, as described in contemporary psychiatry, might be nothing other than (normal) reactions to extraordinary events. In such a case these states are not disorders, but quite the opposite - meaningful states and an effort to introduce some order. The very name of a »mental disorder« is problematic.

However, if the norms for defining mental disorder are social rather than medical, then a medical model becomes unsuitable for psychiatry. This could result in a radical change in diagnostical approaches and treatment. If psychiatric states are not mental disorders, then psychological and social approaches are more appropriate. This means that instead of medicalisation, approaches such as psychosocial interventions, psychotherapy, contributions from users'associations, changes in social structures and a broader acceptance of diversity of human experiences ought to be introduced as more suitable answers to these problems.[1]

Critiques of the concept of a mental disorder

The main critiques of the concept of a mental disorder are psychological, evolutionary and sociological.

1) The psychological theory of mental disorders has the tendency to »normalise« mental states, as opposed to psychiatry, which has the tendency to »pathologise« them. As a science of mental functioning and behaviour, psychology tries to understand behaviour in various ways. One way is the statistical approach which considers every variety in behaviour a part of the total range of behaviour. It means that if we take any characteristic, the majority of the population possess some average value, and very few people are on the extremes of the distributive curve. For example, if we were to assess personal intelligence, the majority of the population would possess average intelligence, and very few would possess very low or very high intelligence. We can similarly distinguish someone who is extremely sociable, has a wide social circle, likes noise and is always surrounded with people from the opposite extreme of an extremely unsociable personal without close friends, who feels uncomfortable in the presence of people. Psychology does not consider it a deviation from normal sociability; it is just on one of the extreme ends of the distributive curve. It does not mean that it is an illness or a disorder that has to be cured. From the psychological perspective, we try to sensibly understand such behaviour.[2]

The psychological approach to normality has very important implications for the shift in the understanding of mental disorders. From the psychological perspective, a mental disorder is mental abnormality. Abnormality carries normative and evaluative weight, firstly by implying that the mind is not functioning as it is supposed to. Secondly, a disorder is implicitly considered a rare deviation within the general population. The third implication is that normality/abnormality is a dichotomy and that term »disorder« implies that someone can be only normal or abnormal. The fourth implication is that persons who assess some behaviour as »normal« or »abnormal« presuppose that they are mentally normal, so normality becomes connected to belonging to a certain community of mentally normal people, while mentally abnormal persons are excluded from the normal community.

The psychological approach undermines such an understanding of the concept of a mental disorder, because statistical rarity is a more or less arbitrary characteristic, and normality is not a binary category. Psychological models of mental functioning and related therapeutic approaches seek meaning in apparently senseless emotional reactions, so something which might have initially seemed abnormal eventually appears normal. Some symptoms of a »mental disorder« can be sensible attempts to solve a problem. The psychological theory of mental health is abundant with such examples.[3] In general, the psychological model of psychopathology focuses on normal functioning and assesses inadequate emotions within the context of a person's wider experiences, trying to understand symptoms as strategies for solving problems.

2) According to the evolutionary perspective (Cosmides and Toby in Bolton, 2008; Richters and Hinshaw in Bolton, 2008) the concept of a mental disorder can be defined in the following ways:

(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 environment or the internal […]« (Bolton, 2008: 78) Living beings use the strategies of coping and defence – they try to compensate for psychological dysfunctions caused by damage to neurological structures and the behaviour which they manifest is a strategy for coping with the dysfunction.[4]

(ii) Strategies that include disruptions of function
The loss of a function may occur because of a higher hierarchical need for survival. That is the way that something that seems to be a disorder is, in fact, order.[5]

(iii) Evolutionary design/environment mismatches
As behaviour is designed to ensure viability in a certain environment, dysfunctional behaviours may appear due to a transfer to a different environment. In an evolutionary context, dysfunctional behaviour may arise from the disparities between evolutionary design and the current environment, if the environment for which the behaviour was designed is different in significant aspects. For example, a child growing up in an emotionally and intellectually nonstimulative environment can exhibit a lack of empathy as an adult.

(iv) Phenotypes that seem maladaptive, but may be adaptive
The evolutionary theory argues that maladaptive behaviour is never selected, so a persistent behaviour has to be connected with a certain adaptive function. Given the fact that mental disorders endure, we can conclude that such behaviour has some adaptive function. So, from the evolutionary perspective, mental disorders are not disorders at all.

(v) Highly evolved learning capacities leading to maladaptive behaviour
In general, evolutionary design gears us with the ability to learn, but we can also use these capacities to develop certain dysfunctional behaviours. A common case is the transfer of learnt patterns of behaviour from the original environment to some inadequate environment.

From the evolutionary perspective, a lot of symptoms are probably coping strategies for surviving in an unknown or stressful environment, and some states classified as mental disorders could be considered adaptive in a different environment.

3) Sociological critiques of the concept of a mental disorder date from the last century. In the 1960's, they became publicly critical and even hostile to the psychiatric approach to mental disorders. Critiques ranged from the idea that modern society took away the meaning of madness, (the medical model of psychiatry displays the tendency to pathologize the meaning of madness and various ordinary everyday problems,) to the concept that psychiatry has the political function of controlling social deviations.

The main critiques were made by Laing (1960) and Szasz (1960). Even though there are various sociological critiques of psychiatry, they all agree that psychiatry defines certain states as disorders in accordance to social values and uses psychopathologi-

cal categories to disqualify and control threats to social structures of power.[6] Sociological critiques of psychiatry exposed the social context and social dynamics of psychiatry by showing that psychiatry, just like any other discursive practice, is embedded in social structures of power and is susceptible to their influence. The problem with such an approach is that it is not individual and does not take into account the suffering of the individual person.

Anti-psychiatry of the 1960's, which attacked the medical model of psychiatry, encouraged the subsequent discussions as to whether the concept of a mental disorder is based on natural facts or is completely dependent on social norms and values. Anti-psychiatry »accused « psychiatry of shifting social norms to medical, therefore taking away the meaning from mental illness, disqualifying illnesses and the people who were diagnosed as ill. In this manner, any behaviour can be diagnosed as a disorder in accordance with the current state of a society or in accordance to the dynamics of social power. Psychiatry thus became a tool for socio-political misuses. Due to the pressure generated by anti-psychiatrical critiques, the concept of a mental illness was replaced by the concept of a mental disorder without further clarifications. The main challenge for psychiatry was to show that its diagnostic practice is based on objective, natural facts rather than on social norms and values.

New paradigm of mental disorder

The new paradigm articulated within the theory of mental disorders is based on genetics and psychology. Methodology derived from the field of genetics has introduced additional complexities and subtle connections. Psychology, especially with its focus on the role of learning in developing behaviours, is sensible to individual differences generated by different learning histories. Psychology, in combination with genetics, is able to recognize how learning histories and genetic differences can produce individual variations. In the new paradigm of bio-psycho-social science, these explanations intertwine to appropriately assess the social, subcultural, family and personal aspects of behaviour. The latest research shows a mutual interaction of genes and environment. It is generally accepted that environmental factors can alter the influence of genes in brain development. Variations in behaviour are a reflection of the mutual interaction of genes and environment, as well as one's social environment and the very process of socialization. A genetic, evolutionary and psychological paradigm replaces the idea of psychological phenotypes as determined only by natural factors and the dichotomy of the natural and the social.

Several authors have been trying to elucidate the nature of »a natural fact«, the core point of dissent within the debate about mental disorders. The most influential among these authors, Christopher Boorse and Jerome Wakefield (Malatesti and Jurjako, 2016), argue for a certain form of naturalism. Both authors presuppose that the concept of a mental disorder includes scientific, objective and natural norms, as well as social norms. The task was to precisely define the characteristics of a psychological dysfunction without including social norms and values. Boorse argues that the natural fact at the basis of a mental disorder is a matter of statistical abnormality. There are several problems with such a statistical definition. One of them is the question of differentiating a dysfunction from a disorder. It is not clear why different functioning, as long as it causes

no harm, ought to be regarded as dysfunctional. The next problem is that deviations from the norm are usually a matter of continuity rather than category, especially concerning characteristics that are normally distributed. From a statistical perspective, the point at which a difference becomes a dysfunction is entirely arbitrary, so the concept of dysfunction is insufficient for determining pathology. The benefits for an individual and their natural functioning should not necessarily overlap (Cooper in Malatesti and Jurjako, 2016: 181). Furthermore, there is the problem of relativity regarding all the questions of statistical deviations within a larger population, due to huge interpersonal differences in environmental features and in the mutual relationships between individuals and their environment. It leads to inescapable relativity in the judgement of statistical normality and deviations. In practice, this significantly influences the judgement of psychological normality, thus shaping social experience, values and expectations.

In his theory of mental illness, Wakefield acknowledges the evolutionary design of mental functioning and behaviour. For him, since correct functioning hinges on the purpose for which the mechanism has been designed through evolution, a dysfunction is a deviation from the designed function. Wakefield's evolutionary naturalism introduces a new important criterion for diagnosing mental illnesses - the person has to undergo what their surrounding cultural context perceives as a harm. The harm creates the condition in which a mechanism is not able to perform its natural function. Wakefield considers a natural function to be the result of the evolution of the mechanism's structure (Wakefield in Malatesti and Jurjako, 2016: 183). Evolutionary naturalism seems to show that a valid diagnosis cannot be descriptive. If we were to accept evolutionary naturalism, the reliability of a diagnosis would become unsustainable. In such a case, a new scientific programme in evolutionary psychology and psychiatry would be necessary to differentiate genuine mental disorders caused by a dysfunction in evolutionary design, from mental disorders which may seem like that, but which do not include a mechanical error of an evolutionary nature, such as stress related conditions. This difference between genuine disorders and disorders that purely resemble them has no practical usage and is just an abstract theory.

Both authors consider the concept of social norms crucial for determining the concept of a mental disorder and both attempt to define the foundations of natural, non-social, medical dysfunctions. The elaboration of Boorse's and Wakefield's ideas emphasized the problems of naturalistic approaches to this field and elucidated the foundations of naturalism's practical inadequacy, leading to many social questions about the interaction between psychiatric diagnoses and practice. »Natural« is difficult to distinguish from »social« on this level of science. While »natural« means evolved and genetically inherited, it also implies evolution and the influence of genetic inheritance on social behaviour. There are additional individual variations and each phenotype is the result of the interrelationship between genetic and environmental factors. Bolton says: »What is natural in the sense of evolved is a factor involved in the production of individual and social behaviour, it is not a third factor» (Bolton, 2008: 181). We cannot make this distinction in psychological functioning, and it is likely that distinguishing between natural and social functions is easier in physiology and general medicine.

Attempts to conceptualise mental disorder without including naturalistic definitions generally agree on describing mental disorders with the notions of harm, suffering, pain, and the necessary response disrupture is painful and causes suffering.[8] As a possible

solution to amending this issue, mental disorders can be defined as a disrupture of meaningful relationships. It is crucial to emphasize that this kind of disrupture is painful and causes suffering. Psychological approaches of the last century, as well as contemporary ones, are finding meaning even where seems to be none. Psychological etiological models of psychiatric conditions imply that certain learning processes can evolve in difficult situations in order to satisfy specific needs. These learning processes became abnormal because they developed in unusual or extreme conditions. This is why these learning processes included distortions and emptiness. Such explanations support the idea that maladaptive and dysfunctional behaviour may stem from troublesome experiences, and that the consequential learning processes develop in an attempt to manage in such circumstances. The entire process is understandable within the context in which it occurs. Although it could be understandable within that particular context, the fact that the behaviour is dysfunctional in relation to the person's needs and values, and in relation to our perception of those needs, is what determines a mental disorder. This brings us to the possibility of defining a mental disorder as a concept involving maladaptive meanings. »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- the fact that it brings about harm, and specifically, more harm than good.» (Bolton, 2008: 189) According to psychological models, certain conditions in psychiatric manuals include some degree of meaningful processing despite being the results of lesions.

This is best illustrated by delusions, states which are taken to be symptoms of psychiatric disorders and which are susceptible to various explanations, be it social indoctrination or theories of rational responses to extreme circumstances.[9] An example is a belief which seems to be rational, but becomes irrational within an individual's surrounding cultural context. We could therefore state that each human experience involves some degree of meaning and rationality. Defining a mental disorder as a mere lack of meaning is too extreme as it would exclude most of the conditions listed in existing psychiatric manuals (Bolton, 2008).

The hermeneutical stance

The very term of a mental disorder implies the existence of a certain order and the assumption that this order can be distinguished from the disorder. This assumption does not arise from psychiatry itself, but from the culture in which psychiatry is imbedded. So the idea that absolute natural order exists in the way of complete freedom of social norms, values and understanding is simply impossible. Works on the history and the epistemology of psychiatry (Aragona, 2013) suggest that psychiatry is in crisis because it relies on the implicit theoretical assumption that the DSM is atheoretical and that mental symptoms are observed on a purely descriptive level.

The Cambridge school (according to Berrios' 2013 and 2014 works, this is the joint term for referring to several scientists focused on the history and epistemology of psychiatry) postulated the notion that the process of »diagnosing» does not proceed from the bottom to the top of the abstraction, i.e. from the description of the symptom to the conclusion of a diagnosis, by applying impersonal and operational diagnostic criteria. On the contrary, »diagnosing« relies on a hermeneutical circle in which the parts, men-

tal symptoms, and the whole, a psychiatric diagnosis, are interrelated (Aragona, 2013). This implies that establishing a diagnosis in accordance to the principles of verifying a patient's symptoms and composing a picture that corresponds to a certain diagnostic category described in the DSM cannot be the approach to psychiatry. According to these scientists, since a diagnosis is the product of dialogue between psychiatrists and their patients, it shouldn't be understood as external to their relationship.

Subjective utterances about a bad mood or notions of hearing voices are by definition mental states which a person is aware of and which are made on the basis of interpreting inner experience. Regardless of the cause, be it spontaneous brain activity, a brain disease, stresses in everyday life, traumatic experiences, or some combination of them, there has to be a certain change which a person becomes aware of. Introspective reports inevitably include difficulties of a theoretical/epistemological and a practical nature. In order to be able to say something about an experience, the subject has to be able to identify it, distinguish it and name it.

The Cambridge school calls this first experience »the primordial soup». »The primordial soup» is a prelinguistic and preconceptual experience which a patient experiences through raw directness. Even though the subject is aware that something has happened inside them, in this phase it is still a protoexperience. In order to become a »subjective mental symptom«, this experience has to pass through several phases of interpretative activity.

In the first phase, the factors that determine the development of the 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, involve more or less memories, be similar to something already experienced or be completely unknown, or like). These factors play a crucial role in the configuration of the experience itself.

In the second phase, factors concerning the personal and sociocultural context become crucial for the further configuration of the changes which a subject experiences in their consciousness. This is the first hermeneutical step, i.e. a patient's self-interpretation of their own experience on the basis of personal, family, social and cultural styles of shaping and naming experiences. Crucial factors include previous experience, personal traits, education, influence of the media, use of language and like. Likewise, a personal proclivity for introspection may generate a more detailed description of one's experience, the level of education may determine the range of vocabulary which a person uses to describe their experience and their culture's attitude towards open displays of emotion can lead to »cognitive« or »somatic» descriptions of the experience, and so on. Glover (2014: 119) says that a number of thinkers have stressed that a human is a self-interpreted animal.

The third phase is the second hermeneutical step in which the influence of interaction plays a crucial role in configuring the experience into what is called a »mental symptom«. The crucial factor in this phase is the encounter with a therapist who can influence the formation of a certain symptom. It means that when a person struggles to make sense of an experience, a therapist significantly influences the assessment of that experience through direct suggestions or the process of construction. This is especially

important in the instances when dialogue can assist the subject in articulating their experience. Of course, this is the very moment when a psychiatrist or psychotherapist can act therapeutically by helping their patient understand their complex and unusual experience in an acceptable way. However, therapists can introduce their own prejudices into the conversation, including them into the final definition of a mental symptom. A mental symptom is a complex construction.

This is why diagnosing is never a neutral description, but rather an active mutual construction of mental pathology. For the same reason, a crystalized mental symptom is not a pure »object«, but a complex product of the interplay of several different factors. It is important to notice that a psychotherapeutic encounter involves no equal epistemic positions between a therapist and their client. A psychotherapist has a different type of epistemic responsibility which requires them to be not only a reliable source of interpretations and information, but an impartial listener capable of creating a context of mutual trust (displaying a neutral approach to testimony and to assessing their patient's credibility). Therefore, it is important to accentuate the importance of the virtue of epistemic trust in a psychotherapeutic encounter, and the asymmetry inherent in the demands of epistemic responsibility between the psychotherapist and their client.[10]

Asymmetry of epistemic responsibility in the communicative act of psychotherapy

Epistemic responsibility is generally defined as the speakers' unwillingness to deceive their interlocutor. However, the epistemic responsibility of a psychotherapist is far more complex than this definition, as it includes the concept of testimony as specifically elaborated within the »epistemology of virtue« (Miškulin, 2016).

Given that every psychotherapeutic dialogue necessarily entails an asymmetry of power in the psychotherapist's favour, the client is bound to absorb their therapist's theoretical framework. It is therefore extremely important for the psychotherapist to be epistemically responsible - to question and reflect on the settings of psychotherapeutic theories, their scientific foundations, as well as the personal value judgements and possible prejudices which they themselves introduce into the psychotherapeutic encounter.

As an epistemic agent, the psychotherapist must satisfy the virtue of epistemic responsibility - understood within the epistemology of virtue as a disposition of intellectual conscientiousness, caution and courage. Therefore, in order to be epistemically responsible, the psychotherapist needs to satisfy the virtues of empirical accuracy, empirical adequacy, self-reflection and the eagerness to critically assess existing theoretical approaches. The psychotherapist's statements must be epistemically responsible and relevantly adhere to existing knowledge. This may be manifested through the psychotherapist's willingness to question the scientific credibility and the truthfulness of diagnostic criteria, or their continuous assessment of the truthfulness and scientific adequacy of certain psychotherapeutic theories. The epistemic responsibility and empirical adequacy of a psychotherapist are comprised of their sensitivity to evidence, mostly in terms of healthy scepticism towards the scientific adequacy of the concept of a mental disorder and the existing psychotherapeutic theories, as well as in reflecting upon their own theoretical background and prejudices. The following examples will help to illustrate this.

An example that accentuates the importance of a psychotherapist's epistemic responsibility is the »looping effect«. Hacking (1995) states that classifying people affects those classified by altering their perception of self. People who are classified into different categories begin to behave in accordance to what society expects from those classified categories. This generates what is called the »looping effect«, also known as the feedback effect, understood as the likelihood of classifications altering those classified by influencing their behaviour.

The following example corroborates the importance of a psychotherapist's epistemic responsibility, in the sense of intellectual conscience based on reflecting upon one's own theoretical background. Al-Shawi (2006) questions the insight-oriented approach to psychotherapy and its objectivist foundations, assessing the claim that improving the patient's self-awareness, self-knowledge and personal insight are necessary prerequisites for achieving positive therapeutic changes. The non-hermeneutic approach to psychotherapy traditionally presumes that a client's progress within psychotherapy is a sign of improved self-perception. The author examines the epistemic features of the concepts of insight and self-knowledge in those approaches to psychotherapy which present their theories as true. Psychotherapeutic theories that offer comprehensive explanations for the behaviour of patients traditionally strive to encompass all possible patients and situations. According to the standard insight-oriented approach to psychotherapy, the client is assisted in discovering the truth about themselves and thus achieving self-knowledge (Jopling, 2001).

According to these ideas, this leads to progress in therapy and is a prerequisite of the client's acceptance of a true insight or, in other words, the client achieves progress by gaining insight and acquiring knowledge about themselves.[11] Such approaches to psychotherapy suggest that the patient is capable of »knowing« or »coming into contact with« their »real«, »internal« or »authentic« self, further assuming that this is true and, as such, a desirable goal of a psychotherapeutic communicative act. The patient discovers the truth with the aid of a therapist who offers interpretations congruent with their theoretical framework and supports the patient in discovering their already existing self. The key assumption is that the self was not created during therapy, but was only brought to the surface. Acquiring such »true knowledge« is a key condition of therapeutic change that can diminish the patient's symptoms.

Accordingly, a therapist of such orientation understands insights as true knowledge about oneself, which includes knowledge of the patient's psychological and emotional features, the structure of their personality and their behaviour.

Al-Shawi (2006) postulates the following questions:

> Is there really a »genuinely« diachronic self that can be unearthed through the usage of a certain theory and method? If there is, can such knowledge be gained through insight-oriented psychotherapy? Or is such understanding based on a hypothesis derived from a certain worldview and a certain concept of experience that presupposes the existence of self?

A psychotherapist with such an approach is placed in the position of a liberator and an expert in facilitating »insight« and »self-knowledge«. However, the critical analysis to which Al-Shawi subjects such approaches reveals that this »knowledge of self« is

nothing more than acceptance of the psychotherapist's perspective and their philosophical assumptions. The client internalizes the concepts of selfhood, knowledge and reality, which the psychotherapist introduces into the psychotherapeutic encounter through their prejudiced adherence to a theory that presupposes the existence of a self waiting to be revealed.

In such circumstances, it is highly likely that the client will deliberately adopt such »self-knowledge« during the psychotherapeutic process. In other words, the psychotherapists whose psychotherapeutic approach is based on the assumption that the »real« and »true« self can be discovered, realize that very assumption within the psychotherapeutic process by unconsciously constructing it.

While clients perceive this »new knowledge« as a »revelation« about their true selves, it is actually a construct created by interpreting a client's thoughts, feelings, and behaviour in a manner that supports the theoretical model of the psychotherapist. However, the client experiences this as an »insight« or a »discovery about oneself«. Ehrenwald (1991) illustrates this process through the fact that most patients who undergo Freudian analyses tend to produce Freudian dreams, Jung's patients produce Jungian dreams and Adler's patients produce Adlerian dreams. This demonstrates the clients' tendency to shape themselves in relation to the applied therapeutic model. Every psychotherapeutic process entails the client's »adoption« of the therapist's philosophical settings related to the nature of knowledge. As a dialogical practice, psychotherapy is comprised of processes which construct knowledge.

As previously noted, psychotherapists should be aware of their privileged position of power within the therapeutic relationship, and carefully reflect on theoretical assumptions about psychopathology and psychotherapeutic theories. They may otherwise mistakenly perceive the beliefs which patients create about themselves during therapy as facts independent of their own theoretical presuppositions.[12]

Many therapists and philosophers (Al-Shawi, 2006; Calestro, 1972; Strupp, 1972; Frank, 1989; Jopling, 1998) state that numerous components play a key role in the psychotherapeutic encounter, which affect the outcome of therapy. Some of these components are: the client's desire for clarity and true and accurate interpretations (Al-Shawi, 2006; Strupp, 1972); the client's urgent desire to relieve their symptoms and the therapist's perception of whether this is possible; the effects of the therapist's attitudes, personality, beliefs and emotional reinforcement (Al-Shawi, 2006; Jopling, 1998); also, the therapist's position within the community and its influence on pressuring the patient to accept the psychotherapist's knowledge as an authority (Al-Shawi, 2006; Calestro, 1972; Jopling, 1998). These factors act in a subtle and unnoticeable way by subjecting the client to the therapist's epistemological framework, thus having a key influence on the outcome of therapy.

Another example which emphasizes the importance of epistemic responsibility and the necessity of empirical adequacy in a psychotherapeutic communicative act is empirical literature on the power of self-fulfilling stereotyping. In this sense, stereotypes are understood as social expectations from certain people, which in turn strongly influence those persons' behaviour in discursive and intellectual activities such as psychotherapy. Research shows that the initial impression and stereotypes affect social relationships

by leading to the confirmation of those impressions and stereotypes in the behaviour of the perceived subject (Rosenthal and Jacobson, 1968; Snyder, Tanke and Berscheid, 1977). The theory of labelling (Scheff, 1966) suggests that once a person is labelled as mentally ill, society starts perceiving them in terms of stereotypes. The public generally perceives psychiatric patients and former psychiatric patients as a threat and as socially undesirable individuals (Calicchia, 1981; Crumpton, Weinstein, Acker and Annis, 1967; Franchia, Canale, Cambria, Ruest and Sheppard, 1967). According to the theory of labelling, on the basis of these findings, people systematically adjust their expectations when encountering someone whom they think currently is or once was a psychiatric patient. Individuals labelled with such diagnoses of mental disorder can incorporate societal expectations into their perceptions of self (Jones et al., 1984), leading to their tendency to confirm those expectations through their own behaviour. In this way, the interlocutor's prejudices become determinative of the subject's behaviour and thus lead to a »self-fulfilling prophecy«.

The results of research on the effects of subjecting psychotherapeutic clients to stereotypes on their social relationships (Sibicky and Dovidio, 1986) show that they are perceived as less desirable interlocutors in social relationships than non-clients. The aforementioned research on self-fulfilling stereotypes shows that subjects behave more negatively towards clients than towards non-clients, and that clients themselves behave in a less socially desirable way than non-clients. Studies related to education, also mentioned by Fricker[13] (2007), have shown that teachers' expectations of their students' intellectual success influences those very students' intellectual achievements. More precisely, teachers' high expectations somehow produce high achievements in their students.

Furthermore, studies in clinical psychology (Dembo and Clemens, 2013) carried out on several cases in psychotherapy, show that the therapist's optimistic outlook on the likelihood of the patient's recovery, even in cases of hard to cure mental illnesses, positively affects the outcome of the therapy, unlike the stance that the patient's condition is incurable. The authors conclude that it is ethically correct to convey feelings of optimism and positive illusions in psychotherapy. This confirms that the therapist's attitude towards their patient and their previous »knowledge« about the likelihood of curing certain mental disorders contribute to the success of psychotherapeutic treatment. The »knowledge« introduced by the therapist attains the status of prejudice towards the patient. If being optimistic about the prospect of recovery contributes to psychotherapeutic success, then proving that something is (non)curable, without addressing a previously existent attitude towards the (non)curability of a particular patient, becomes questionable.

Even if it were possible to have a neutral attitude towards curability, such a stance would be yet another bias that would negatively affect the outcome of therapy. It would seem that a psychotherapist is morally obliged to have a positive attitude towards the curability of their patient in order to increase the likelihood of fulfilling the therapeutic aims. We could say that any other therapeutic attitude towards a patient's incurability functions as a negative bias, becoming a self-fulfilling prophecy that hinders effective psychotherapy.

Implications for psychotherapy

The aforementioned epistemological research in psychiatry (Aragona, 2013) shows that mental symptoms and psychiatric diagnoses are mutually dependent constructs created within the therapeutic encounter (Berrios, 2013, 2014). According to the authors, the clinician may play a crucial part in articulating symptoms, especially when it is difficult for a subject to autonomously make sense of their experience. This happens within the hermeneutical process that engages mutual influences which configure the entirety of the patient's experience into a »mental symptom«. A clinician who communicates their working hypothesis to their patient is possibly introducing personal prejudices that can influence the final description of the patient's mental symptom. As repeatedly mentioned, a clinician's position can never be entirely neutral. Similarly, a description made during the process of establishing a diagnosis is never neutral. On the contrary, a description plays an active role 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.«(Aragona and Markova, 2015: 609)

Thus, it becomes evident that establishing a diagnosing through a hermeneutical process can potentially both assist and hamper therapy. Shaping and naming an experience can be a therapeutic procedure if the experience becomes part of the patient's meaningful life, or, *vice versa*, it can be harmful to disqualify an experience as senseless or ill from the presupposed position of »neutrality«.

These described influences present in psychotherapeutic communicational acts are realized through subtle and primarily unconscious processes external to the explicit awareness of either party. The psychotherapist's theoretical orientation, their knowledge about the non/curability of a certain psychopathological category with which a patient has been labelled, their expectations of a patient's behaviour in psychotherapy and their personal prejudices toward certain classes of people can significantly influence the course and the outcome of a psychotherapeutic process.

Personal awareness of the psychotherapist's own psychotherapeutic orientation, their attitude toward curability and their predictions of psychotherapeutic success, rests at the very core of psychotherapy to become part of the psychotherapist's ethical and epistemological responsibility.

Conclusion

Contemporary debates within the philosophy of psychiatry show that the concept of a mental disorder is socially constructed. To recognize the impossibility of defining a mental disorder in absolute terms, without acknowledging the culture in which it evolved, means to think of the concept of a mental disorder as a hypothesis that is worthy of future research. At this moment, it means to be engaged in a continuous dialogue about various possible interpretations of mental disorders, and to define psychiatry as a discursive activity that is not exempt from the culture and the society in which it is practised. This also applies to psychotherapy as a discursive activity and justifies the encouragement of hermeneutic approaches to psychotherapy i.e. psychological approaches to the treatment of persons with mental disorders. This is especially relevant for hermeneutical approaches to psychotherapy founded on the view that a mental disorder is constructed within a communicational act between a clinician and their patient.

Given that the epistemic asymmetry inherent in the relationship of a therapist and their client favours the therapist, as shown by numerous examples, the psychotherapist is obliged to approach the client in an epistemically responsible and empirically adequate manner. This requires sensitivity to the evidence, understood as healthy scepticism towards the scientific foundations of the concept of mental disorders and psychotherapeutic theories, as well as critical reflection upon their own theoretical presuppositions and prejudices.

Comments

[1] *This can be illustrated by the exclusion of homosexuality from the DSM III manual in the early 1970's. We are nowadays confronted with a similar question of whether vivacious children who are diagnosed with ADHD are pathologised in manner resembling the former treatment of homosexuals. The same is the case with medicating older people due to declines in mental capacities, which might be quite normal for their age.*

[2] *Bolton (2008) cites the statistical fact that 25% of the population suffers from a major depressive episode at least once during their lifetime. This implies that it is a normal human experience.*

[3] *Once such example is the occurence of panic attacks, following some traumatic experience, in situations recognized as identical or similar to the context of the original traumatic experience, such as the fear of driving after a car accident as protection from possible danger.*

[4] *Contemporary models of autism and schizophrenia follow such an explanation, presupposing that behaviours characteristic for such disorders are of an adaptive nature.*

[5] *For example, Malatesti and Jurjako (2016) say that some authors argue that psychopathy is an evolutionary adaptive strategy for survival rather than a mental disorder.*
[6] *Bolton (2008) offers an example of the usage of the concept of a mental disorder as*

a means for ensuring social control dating from the middle of the 19th century, when slaves who tried to escape were diagnosed as »drapetomaniacs».

[7] *While manuals such as the DSM acknowledge the problems which cause people to come to a clinic, they do not explain whether these problems include everyday and socially defined problems.*

[8] *Foucault defined madness as a lack of rationality and meaning (Foucault in Bolton, 2008: 183)*

[9] *For example, Glover (2014) claims that some delusions are results of social indoctrination and can thus be cured through arguments, such as those offered in Richard Dawkins' book »The God Illusion». He differentiates them from delusions which could be a rational response to unusual circumstances or an attempt to make sense of an extreme experience.*

[10] *Epistemic responsibility generally rests on the speaker's unwillingness to deceive their interlocutor. However, the epistemic responsibility of a psychotherapist is far more complex than such a narrow definition, as it includes the concept of testimony specifically elaborated within the epistemology of virtue. See more in Miškulin (2016).*
[11] *Insight is, for example, the key concept of psychoanalytic theory and other approaches to therapy that explore the psychological structure of their patients. Despite the different features and contents of a patient's insights, most insight-oriented approches to psychotherapy agree that an insight is the moment or stage when the client finally understands the reasons behind those choices, behaviour and emotions that were previously troubling and difficult to understand.*

[12] *Numerous studies on false memories support this by suggesting that »the presence of implicit meanings in conversation increases the likelihood of recalling false memories instead of actual experience.« (Brainerd and Reyna, 1998: 488) The situation becomes even more impressive when we know that the patient considers their psychotherapist a trustworthy authority, and research suggests that false memories are the most frequent outcome of dialogue with a person whom the patient perceives as an authority. While attempting to use questions and interpretations to determine the »reality« and »knowledge« which serve as the patient's framework, the therapist actually subjects their patient to their perspective, epistemology and ethics. Consider, for example, the question: »Does anybody in your family have such a problem?« This question not only describes the patient's state as a problem, but postulates a family history of similar states as relevant to finding a solution. While the client is free to question the relevance of noticing similar issues within their family, they would still need to accept the given theoretical framework in order to participate in a meaningful discussion. However, what matters is the fact that the listener would consider the topic unimportant if it had not been mentioned in therapy. The question has created a specific framework which somehow affects the remainder of therapy. Consequently, the question outlines a new area of »knowledge« in the therapeutic process. The therapist uses questions to lure the patient into a specific philosophical framework which confirms their authority, and the client readily conforms.*

[13] *Fricker (2007) mentions research by Rosenthal and Jacobson (1968), Englewood (1980), Snyder, Tanke and Berscheid (1977).*

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