PSYCHOSIS FROM A SECONDARY PERSPECTIVE: CONTRIBUTIONS OF PHILOSOPHY TO THE PRACTICE OF PSYCHIATRY

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ABSTRACT

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Traditional third-person symptom-based diagnostic-treatment methods do not adequately address the subjective experiences of psychotic patients; reductionist biopsychiatry fails to comprehensively assess subjective experiences and treatment difficulties. Alternatively, first-person perspective practices and the biopsychosocial model are also incompatible with the scientific paradigm and fail to identify diagnostic-treatment goals. Nevertheless, calls to address the shortcomings of first- and third-person perspectives persist in the contemporary academic world.

In response to these calls, a new approach to psychosis based on a second-person perspective is proposed. This approach provides a neuro-psycho-phenomenological, intersubjective, and empathic framework for the diagnosis and treatment of the subjective experiences of psychotic patients through scientific methods. The process is structured around a network of patients, relatives, clinicians, and other specialists.

The epistemic access or subjectivity of the patient is supported through Virtual Reality (VR), the use of the expert's own internal resources (imagination and personal experience), and the inclusion of family members in the process. This

approach allows the expert to access information not readily available from the patient, combining scientific knowledge with their patient-specific insights. Simple psychoeducation for families aims to structure the treatment at home. By involving other specialists, the latest scientific knowledge about psychosis and the personal experiences of the specialists are shared through joint intellectual attention, thus fostering an interdisciplinary dialogue.

In contrast to the dominant model and non-scientific models, this approach is subjective experience-oriented and aims to combine the positive aspects of scientific and subjective perspectives. By integrating a personalized diagnosis-treatment process, this new model seeks to enhance the understanding of dynamic, professional, and intersubjective experiences and to develop a personalized diagnosis-treatment model.

Keywords: Philosophy of Psychiatry, Psychosis, Second Person Perspective, Multi-disciplinary Interaction, Subjective Experience of Illness

ÖZ

İKİNCİL BAKIŞ AÇISINDAN PSİKOZ: FELSEFENİN PSİKİYATRİ PRATİĞİNE KATKILARI

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Geleneksel üçüncü şahıs semptom odaklı tanı-tedavi yöntemleri, psikotik hastaların öznel deneyimlerini yeterince ele almamakta; indirgemeci biyopsikiyatri, öznel deneyimleri ve tedavi zorluklarını kapsamlı bir şekilde değerlendirememektedir. Alternatif olarak sunulan birinci şahıs bakış açısı uygulamaları ve biyopsikososyal model de bilimsel paradigmayla uyumsuzluk içinde hareket etmekte ve teşhis-tedavi hedeflerini belirlemede başarısız olmaktadır. Buna karşın, birinci ve üçüncü şahıs perspektiflerinin eksikliklerini gidermek için literatüre yönelik çağrılar, çağdaş akademik dünyada yapılmaktadır.

Bu çağrılara cevap olarak, Michael Paunen'in tanımlarına dayanan ikinci şahıs bakış açısına dayalı yeni bir yaklaşım psikoz için önerilmektedir. Bu yaklaşım, nöro-psiko-fenomenolojik, öznelerarası ve empatik bir çerçeve sunarak, psikotik hastaların öznel deneyimlerinin bilimsel yöntemlerle tanı ve tedavisini amaçlamaktadır. Süreç, hasta-hasta yakını-klinisyen ve diğer uzmanlar ağı etrafında yapılandırılır.

Hastanın epistemik erişimi ya da öznelliği, Sanal Gerçeklik (VR), uzmanın kendi içsel kaynaklarının kullanımı (hayal gücü ve kişisel deneyimi) ve aile yakınlarının

sürece dahil edilmesiyle desteklenmeye çalışılır. Bu yaklaşımla, uzman hastadan alamadığı bilgilere erişerek bilimsel bilgisini hastaya özel içgörüsüyle birleştirir. Ailelere verilen basit psikoeğitim, tedavinin evde de yapılandırılmasını hedefler. Diğer uzmanlar da sürece dahil edilerek, ikinci şahıs bakışına özel, ortak entelektüel dikkat yoluyla psikozla ilgili en son bilimsel bilgiler ve uzmanların kişisel deneyimleri paylaşılır; böylece interdisipliner bir diyalog kurulur.

Baskın model ve bilimsel olmayan modellerin aksine, bu yaklaşım öznel deneyim odaklı, bilimsel ve öznel bakış açılarının olumlu yönlerini birleştirmeyi hedefler. Kişiye uygun tanı-tedavi sürecinin entegre edildiği bu yeni model; dinamik, profesyonel ve öznelerarası deneyimlerin anlaşılmasını artırmayı ve kişiye özel bir tanı-tedavi modeli geliştirmeyi amaçlamaktadır.

Anahtar Kelimeler: Psikiyatri Felsefesi, Psikoz, İkinci Kişi Bakış Açısı, Multidisipliner Etkileşim, Öznel Hastalık Deneyimi

To the Republic of Mustafa Kemal Atatürk and all women: Each time a woman stands up for herself, without knowing it possibly, without claiming it, she stands up for all women

-Maya Angelou

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CHAPTER 1

INTRODUCTION

> "Maybe each human being lives in a unique world, a private world different from those inhabited and experienced by all other humans. If reality differs from person to person, can we speak of reality singular, or shouldn't we really be talking about plural realities? And if there are plural realities, are some more true (more real) than others? What about the world of a schizophrenic? Maybe it's as real as our world. Maybe we cannot say that we are in touch with reality and he is not, but should instead say, His reality is so different from ours that he can't explain his to us, and we can't explain ours to him. The problem, then, is that if subjective worlds are experienced too differently, there occurs a breakdown in communication and there is the real illness (Dick, 1985)."

This statement by Philip K. Dick emphasises an excellent insight into an important point for philosophy. Subjective worlds will indeed consist of different experiences (or vice versa), and this will create a dissonance or disconnect between the different worlds. Although Dick may have referred to the explanatory gap in academic philosophy as the explanatory gap by Joseph Levine in 1983, he has addressed it both before Levine and in the philosophy of psychiatry. Therefore, Dick's remark can be considered as one of the pioneering comments in the field of philosophy of psychiatry. Yet psychiatry did not develop in a philosophical orientation; modern psychiatry originated and progressed from another direction: The origin is science.

The biomedical symptom-based model, which serves as the paradigm of psychiatry in today's world, adopts and accepts scientific, positivist, mechanistic, and biological-reductionist principles on the basis of a third-person perspective. The National Institute of Mental Health (NIMH) of the United States of America, one of the leading centres in the adoption and implementation of this model, states that psychiatric disorders are brain disorders (Fernandez, 2016). Consequently, the causes of psychiatric disorders were of neurobiological origin. Thus, these origins can be classified, and

by determining disease effects on individuals, appropriate treatment can be provided. Therefore, various psychiatric diseases can be successfully controlled with medication. Finally, psychiatry can treat complex disorders such as psychosis.

Even psychosis has always been an interesting, challenging, and even frightening subject and disorder; it has complex scientific and social dimensions. The reason for the fear and hesitation can be understood both in terms of the strangeness of patients' behaviour and the nature of the illness itself. The invisible nature of mental health and mental illness has the potential to delay access to treatment, leading to misunderstandings by both patients and professionals. However, these factors lead to problems such as the inability of psychiatry to treat psychosis effectively and quickly. One of the main reasons for these problems may be the reliance on a third-party, observable, symptom-orientated approach to the diagnosis and treatment of psychiatric disorders. Since the objective perspective used in treatment excludes the phenomenological nature of psychosis, this perspective ignores communication and interpersonal relationships in treatment.

As a result, the patient's experiences are pruned in favour of a systematic description of symptoms, and the patient's trust in the professional and treatment is reduced due to the neglect of intersubjective relationships in the treatment process. In addition, the standardised approach of the treatment may not suit the patient. At the end of the treatment method tried, because there is no other alternative, psychosis may not be treated appropriately, leading to misdiagnosis or de- layed diagnosis by professionals. Thus, psychosis continues to be lived in discomfort at the level of the patient, the patient's relatives, and society.

For psychosis, however, a delicate balance must be considered. Variables such as the way the patient experiences the illness, the experiences of the illness, the process, and the way the patient relates to other people are personal and unique. In addition, the phenomenological aspect of hallucinations and delusions is a fact. This phenomenological aspect is so dominant and important that it can even name the type of the disease. For these reasons, the subjective and dynamic aspects of both the patient and the disease should be recognised and integrated into the diagnosis-treatment process.

Today, the dominant attitude is the biomedical-symptom view, developed and shaped in a third-person perspective. In contrast, phenomenological psychiatry, which is an alternative method, continues its development within the first-person perspective. This thesis advocates the integration of both views into psychiatry, recognising their necessary and important aspects. Especially because of the highly phenomenal aspect of psychosis, this integration is not a marginal orientation or a radical proposal but a necessity. One of the main claims of this thesis is that this integration can be established on the basis of philosophy, from a second-person perspective. The mechanistic-reductionist, standardised, heteronormative approach proposed by the third-person perspective, which focuses on observed symptoms and behaviours to the exclusion of patient complaints, is criticised, but its realistic and scientific aspects are accepted. Similarly, the non-cognitive, purely personalised, meaning-orientated, qualitative thematic analysis and non-scientific aspects of the first-person perspective are excluded; the phenomenological aspects of patients and illness are embraced.

The thesis criticises the mechanistic-reductionist, standardised, heteronormative approach proposed by the third-person perspective, which focuses on observed symptoms and behaviours to the exclusion of patient complaints while accepting its realistic and scientific aspects. Similarly, the non-cognitive, purely personalised, meaning-orientated, non-scientific aspects of the first-person perspective, involving qualitative thematic analysis, are excluded; the phenomenological aspects of patients and illness are embraced. Scientific and phenomenological adoption is defined on the basis of philosophical psychiatry, based on the second-person perspective. The impenetrable phenomenological aspect of the first-person perspective is softened by factors such as technological equipment and the social environment. After, the intense and insurmountable phenomenon of psychosis will be softened, the first-person perspective can be taken into account, and individualised diagnostic and therapeutic methods can be recommended. The economical and widespread methods of the third-person perspective, in which a scientific approach is adopted, continue to be involved in the process. Thus, interpersonal, patient-orientated diagnosis and treatment, in which subjective experiences are embraced, are proposed under the second-person perspective. In conclusion, the second-person perspective proposes a chain of interventions within a neuro-socio-bio-psycho-phenomenal framework, in which interpersonal dia-

logue will be nurtured in the personal diagnosis-treatment process and technological equipment can be used to understand the patient's experiences. In the process, the patient, the specialist, other specialists in the field, and family relatives should be active, since each of them is seen as an epistemological resource in the diagnostic-treatment process. The second-person perspective can also be considered within the scope of the psychiatric philosophy of revolutionary methods such as Avatar Therapy (AT) used in recent years. In this way, the new approaches based on the second-person perspective are a philosophical perspective in which scientific and phenomenological notions are accepted, the insurmountable subjectivity is softened with technological tools and patient relatives, thus paving the way for personalised diagnosis-treatment methods. In the future, it is expected to increase its prevalence in practice with therapies diversified by artificial intelligence (AI), machine learning (ML), and advanced resources such as virtual reality (VR).

In order to prepare the ground for the treatment methods suggested by this perspective, the thesis proceeds as follows:

1. The second part aims to distinguish psychosis from other diseases and conditions that are commonly confused in the general population. Through this distinction, it will first be observed that the observable symptoms of psychosis are not easily recog- nised by the general public, which leads to public exclusion and stigmatisation. Sec- ondly, the psychiatric nature of psychosis is not always clear and comprehensible even to specialists, leading to problems such as incorrect treatment and late diagnosis. Fi- nally, although psychosis has a different aetiology and nosology from other illnesses, these also affect the patient's phenomenological experiences and further complicate treatment.
2. The third part tries to situate the history of psychosis within the history of psychi- atry by considering psychosis as a concept in the history of psychiatry. Thus, it can be seen that the history of modern psychiatry is oriented towards the development of psychosis. In addition, in contrast to the anti-humanitarian attitudes of antiquity, moral treatment starting with Philippe Pinel will be explained in this section as a turning point that initiated modern psychiatry. The impact of the reductionist attitude seen throughout the

short history of diagnostic and treatment systems on modern psy- chiatry will be tried to be observed.

3. The fourth chapter deals with the biological psychiatry and biomedical semptom- based model, which is a modernised version of biological psychiatry, which is one of the most important views in making modern psychiatry scientific. The model is one of the most important methods of application of the dominant paradigm today. Although the model's fundamental arguments are scientific, objective, excluding sub- jectivity and logical positivism, it is criticised for excluding phenomenological struc- tures, including heteronormative structures and not being holistic. At the end of the chapter, it will be tried to show that the problem of inclusiveness created by the dom- inant model is reflected not only in practice but also in the educational processes of the experts, as it presents a limiting approach in a hierarchical, cold, distant attitude that based on biological psychiatry.
4. In the fifth chapter, alternative models that challenge the dominant paradigms and attitudes will be described. Firstly, the biopsychosocial model proposed by George Engels in 1977, followed by Phenomenological Psychiatry based on the first per- son perspective. The biopsychosocial model accepts the biomedical symptom-based model as dogma and, as the name suggests, proposes a holistic approach. However, it has been criticised for the epistemological confusion created by the ambiguity of the concepts of illness and health, the lack of theoretical background, and the trial-and- error nature of treatments. The second alternative is Phenomenological Psychiatry with its strong philosophical background. As the name implies, the views of im- portant philosophers such as Edmund Husserl and Martin Heidegger are accepted in psychiatric practice. The specialists, who see schizophrenia and depression as a prob- lem created by the person in the world of meaning, do not offer scientific treatment to people. Instead, thematic and quantitative analyses are made with approaches based on the phenomenological method. This view is criticised because it does not offer a scientific treatment method, is based on the Diagnostic and statistical manual of men- tal disorders (DSM), which is the source of the reductionist model they criticise, and is only experience-oriented.

5. The sixth chapter will provide a brief introduction to the perspectives and the origins in psychiatric philosophy of the perspectives on which the dominant models depend. In this way, it can be seen that the subjective-objective distinction is two distinctive constructs in approaches to the treatment of psychiatric patients. However, these perspectives are not the ultimate perspectives, and a second-person perspective is also suggested as an alternative perspective. The second-person perspective en- compasses intersubjective social interaction in a reciprocal manner. It is argued that these are transformative and remedial in psychiatric diagnosis and treatment, and that subjective experiences can be softened through dialogue within a scientific perspec- tive. Thanks to the second-person perspective, the treatment between clinician and patient can proceed on a safe ground in an environment that includes phenomenolog- ical elements.
6. The seventh chapter discusses the applications and appropriateness of the second person perspective for the phenomenological structure of the psychotic patient's ill- ness, which is even more layered due to its complexity. This context is explained by the problematic nature of the three items for the second person perspective: replica- tion, self-other distinction and social distinction. Replication is the creation of one's own resources in order to understand the actions, intentions and experiences of other subjects. This can be imagination or recollection of one's own experiences. Self- Other Distinction can be understood as distinguishing one's experiences from other subjects, and Social Distinction can be understood as understanding social interac- tions and dialogues in terms of content. It is shown that psychotics may misunder- stand or fail to understand the intentions, feelings and thoughts of the other in the process of the illness, that they may not be able to make a healthy distinction between self and other, that their perception of reality will be distorted and that they will have problems in correctly evaluating social content, roles and dynamics. Thus, it is aimed to correct the key points of the second person perspective.
7. Finally, in eighth chapter, the patient's communication between the specialist, the patient's relatives and other specialists is prioritised in order to correct these prob- lems. In order to understand the patient's disease process and

experience, the expert can use their imagination, his/her inner resources to recall similar processes. It is also recommended that the patient can use VR to understand the patient's hallucinations and delusions, where the patient's phenomenological subjectivity is most intense. In order to benefit from the personal knowledge and experience of other specialists, the joint intellectual attention proposed in the second person perspective is recommended, and this type of attention is a special type of attention in which specialists focus their subjective experience and scientific knowledge on a single subject (Vanney and S´aenz, 2021).Thus, knowledge and professional experiences about psychosis can be shared among other specialists. Finally, family support can be utilised. The infor- mation provided by the family for the patient can be important. In addition, simple psychoeducation can be given to the family to emphasise that the patient's process is in itself subjective and incomprehensible. All methods can soften the unbreakable and insurmountable subjectivity of the first person with resources such as VR, family information, which are proposed in the second person perspective. Thus, a scientific and ethical treatment can be provided to the person.

CHAPTER 2

WHAT IS NOT PSYCHOSIS?

2.1. Other Concept Conflicts

Mental illness has existed since the beginning of existence, in every place and at all times where human beings have demonstrated their minds and selves. Psychosis is also a well-known manifestation of human performance. For a developmental understanding of the process of this manifestation, one can look to etymology. Although it has been suggested that psychosis is a combination of the Greek word psyche (/mind) and the suffix -osis (-), meaning abnormal state/imbalance, the term was first used in 1845 by Austrian physician, poet, and philosopher Ernst von Feuchtersleben (Beer, 1995; Tomasi et al., 2010). According to the same sources, while its meaning was to describe mental illnesses seen as the opposite of neurosis, the modern definition implies a psychiatric description of a person's detachment from reality (APA, 2013). Although this implication and the area of use of the expression seem to have a clear and clear meaning from a scientific point of view, this does not harbour the same acceptance by all layers of society. In other words, the use of the modern definition of psychosis and its acceptance by the authorities does not mean that it can be easily understood by society.

From a naive perspective, the experience of detachment from reality can encompass a variety of experiences and meanings. People can encounter many situations in which they can easily lose their sense of time and space. For example, a very intense anxiety attack, a severe migraine attack, or waking up from a deep sleep can cause a person to momentarily lose their perception of space and time. Therefore, in similar situations, people can easily lose their sense of time and space. However, this perspective and the common people make a mistake here, because none of these situations is a psychotic

experience or a psychotic episode. However, none of these states imply psychosis and are not experienced as psychotic episodes. However, from a naïve point of view, the experience of detachment from reality may also be open to a certain degree of acceptance and experience by society, as it involves different experiences and meanings. This is because people in society are not scientists and experience reality in ways that differ from reality from time to time. Thus, the public may have inaccurate or inadequate information about the definition and experience of psychosis. However, according to APA, a psychotic episode consists of intense symptoms such as hallucinations and delusions, and these symptoms radically affect the patient's cognitive, emotional, and behavioural processes, leading to distortions in the patient's subjective experience, social dysfunctions, and creating impeirments (2013). According to DSM-5, psychotic processes include intense symptoms such as hallucinations and delusions. These radically affect cognitive, emotional, and behavioural processes, leading to distortions in the patient's subjective experiences, social dysfunction, and maladaptation. All these experiences are considered psychopathological because the physical and psychological integrity of the person is disrupted. So, the process can be quite intense and painful, as the following experiences of a real psychotic patient illustrate

> "Many times I have felt that I was fighting my way up a dirt hill, and as I walked the ground crumbled beneath me, and I could make no movement...Recently, my mind has played tricks on me, creating The People inside my head who sometimes come out to haunt me and torment me. They surround me in rooms, hide behind trees and under the snow outside. They taunt me and scream at me and devise plans to break my spirit. The voices come and go, but The People are always there, always real...Schizophrenia is not just an illness, it is a way of life, and it is a life constantly disrupted by symptoms. I have dealt with a totally delusional world in which I was God - The Creator and The Sufferer - and the trees held magical power while a great wall and glass dome cut me off from the rest of humanity. Today I saw reality, felt it, lived in it for a while. It was exactly as though someone had thrown a switch and turned a black and white TV into color - like the Wizard of Oz. It was incredibly beautiful and extremely intense. I felt every color, heard every light, saw the world as everyone else sees it - as a vibrant, pulsating complex of what life is all about. I heard in my head very distinctly, "I am both The Creator and The Sufferer (McElheny, 1986, para. 14)."

According to the schizophrenia patient, the blurring of boundaries between the person and those around her is most intense and extreme during reality distortion. Some-

times these distortions are so severe and intense that the psychotic person's feelings, thoughts, and perceptions may cause the information coming from the outside world to be interpreted in completely different ways. Thus, the most important symptoms of psychosis are how it distorts reality, but other positive and negative symptoms also affect the process and patient.

The positive and negative symptoms of the disorder can be explained as follows. Positive symptoms can be characterised as situations that detach from reality and contribute to the normal perception and world of psychosis, while negative symptoms can be summarised as situations that impoverish the patient's personal world on an emotional level, cause loss of motivation, and detach the patient from the outside world for DSM-5. Sometimes these distortions can be so severe and intense that the psychotic person's emotions, thoughts, and perceptions interpret external world information in completely different ways. For example, some psychotics believe that certain coloured objects have a special meaning and are used by aliens to communicate with them. Alternatively, they may strongly believe that their family was trying to kill them because spies kidnapped them and used their bodies.

As can be seen, an extreme distortion of the psychotic person's perception of reality in various ways is a symptom of the illness and is very different from a deep siesta.

As a result, the psychotic paints a picture so detached from reality that it becomes clearly observable in everyday behaviour. This disorder, as a projection of the psychic and inner world, manifests itself in various ways in the patient and can also be recognised externally. For example, the patient's experience of his or her own body, speech, appetite, sleep patterns, and untidy clothes are some of the examples that the disorder can be traced back to. Furthermore, due to the dissociation from reality and radical change, the psychotic person cannot understand themselves and will not easy to explain. All this creates a marginal and eccentric appearance and can easily be recognised by other people. Psychosis is therefore unlikely to occur in everyone, as it is different from an intense headache, migraine, or deep sleep. It is also difficult to understand the patient and the illness because of the difficulty in expressing the error itself. In addition to the lack of understanding or misunderstanding of psychosis in

the community, patients can become open targets. The patient may also be confused with other psychiatric illnesses or undesirable conditions in the community because of the patient's remarkable behaviour during the episode. Patients may be seen as perpetrators of threatening violence or may be confused with other psychiatric conditions. In fact, this confusion will not limited to the general public, and specialists may also misdiagnose or delay the diagnosis. Therefore, it is essential that both the general public and professionals are familiar with the distinguishing concepts in their own terms. This will help to avoid marginalisation and fear of psychotics, ensure their inclusion in society, and enable early diagnosis and treatment. In the following, some of the most frequently confused and misunderstood conditions with psychosis will be discussed, and the main differences will be explained. Thus, it will be aimed to understand what psychosis can be by explaining the main differences through the most common mistakes.

2.2. Dissociative identity disorder (DID)

Dissociative identity disorder (DID), formerly known as multiple personality disorder (MPD), is a rare and controversial psychiatric condition characterised by an individual unconsciously claiming to have two or more distinct personalities (Reinders and Veltman, 2021). According to research, for DID, the person asserts that there are at least two personality states or dominant personalities (alters) that continuously control their behaviour. Hence there can be said that a major symptom of DID would be the transition between the alters, in which the person's identity confusion and memory gaps are occurring. In contrast, psychosis is characterised by a detachment from reality and draws a different picture as it also involves symptoms such as hallucinations, delusions, and disorganised thinking for DSM-5. Yet, due to some apparent symptom similarities between the two conditions, they can be difficult to distinguish and can cause some confusion. For instance, one of the most important points in the mistaking of psychosis and DID may be the mistaking of auditory hallucinations. According to the American Psychological Association, both psychosis and DID can exhibit auditory hallucinations. But in DID, the voices heard from outside were associated with different identities, whereas in psychosis, according to Reinders and Veltman, the patient perceives the voices as if they are being spoken to the patient.

Also in both psychopathological conditions, there may be disconnections and fractures between perceptions of reality. On the other hand, in psychosis, this situation shows continuity due to negative and positive symptoms, while DID patients have a more holistic experience and perception of reality except for dissociative periods. As DSM-5, the spectrum of psychosis was very broad; hence some people diagnosed with DID may also experience psychotic episodes. Therefore, the specialist should be careful not to confuse DID with psychosis. A careful assessment of the patient's complaints and a favourable analysis of their condition, as well as listening to his/her personal experiences, are particularly necessary. For DID, the patient's different personality types or transitions should be investigated. Delusions and hallucinations can then be detected and diagnosed as psychosis.

To sum up, these distinctions can be important and difficult but are necessary to determine the appropriate treatment. In that manner, psychosis can be controlled by therapy, especially psychopharmacological treatment, whereas in DID psychotherapy can be used to integrate methods of identification. As can be seen, although the aetiology and nosology have similar patterns, they are two different psychiatric conditions. Even the society confuses these two conditions due to reasons such as lack of information but does not make an effort to find out what is correct. However, a better understanding of the needs of both groups would be beneficial for both the patient and the society in which the patient lives.

2.3. Psychopathy

Psychopathy is another condition indirectly confused with psychosis. Firstly, psychopathy is not an official diagnosis, but it is assessed under the category of personality disorder in DSM-5 (2013). Also, according to Edens et al. (2017), psychopathy can be considered a personality disorder that includes having no remorse for criminal or violent acts, taking pleasure in manipulating others, and a lack of empathy. Although psychopaths do not develop empathy, they have a charm and charm that they can use to influence other people for them. In addition, psychopaths may tend to have high reasoning abilities and a developed perception of reality. On the other hand, psychotic patients' perception of reality is highly impaired, and they have delu-

sions and hallucinations. Moreover, the fact that psychotic patients may be under the influence of hallucinations and delusions does not mean that they will be prone to violence (Kumari et al., 2013). Therefore, psychosis should not be confused with criminal behaviour and psychopathy. It is stated that the treatment of psychopathy is more difficult than psychosis because treatments generally aim to control behaviour.

However, psychosis can be structured that increases the possibility of treatment in early diagnosis as DSM-5. Thus psychopaths can also be more aggressive than people who are called crazy in society. Therefore, psychopathy will be different from the psychotic person and can be expected to have a more dangerous personality pat- tern. Again, psychopaths may be extremely attractive, intelligent, beautiful/handsome people who are admired by society. Psychosis, on the contrary, puts the patient into a very fragile personality structure and makes them vulnerable. Therefore, it would be wrong to see psychotic people as dangerous.

So, all these contradictions may be one of the points that distract from seeing psychosis as dangerous. because knowing the difference between a psychotic and a psychopath will reduce the unfair accusations of the society against psychotics.

2.4. Delirium

Delirium is another common example of a condition that is often confused with psychosis. However, both conditions are quite different from each other. Firstly, delirium can be seen as a medical condition or stage characterised by a sudden disturbance of attention, including loss of consciousness (Trzepacz et al., 2023). It also usually develops over a brief period of time (hours or days). Delirium is often seen among hospitalised older people and can often be caused by a medical condition, medication, or surgical procedures as DSM-5. Therefore, it is likely to be transient and reversible. During this process, the patient may experience fluctuations in consciousness and may experience disorientation or a sense of detachment from place and time. Furthermore, according to Iqbal, and Afridi psychosis can be divided into acute or chronic and occurs in late adolescence or early adulthood. Therefore, onset is a different point from delirium (2019). Since delirium is an emergency, differential diagnosis will be critical

and necessary. Hence emergency and acute interventions may be more prominent in delirium.

Psychotics, on the other hand, may have memory impairments but may still be aware of who they are, where they have been, or their recent past. Psychosis, on the other hand, is a medical condition, defined as a loss of contact with reality, which affects the patient in a wide range of ways. Thus, major changes in the content of treatment and interventions are recognised.

2.4. Madness

Madness and psychosis are two different concepts with different origins and meanings, historically and culturally. Madness is a term used informally to refer to what are in reality vague psychopathologies, while psychosis is the specific clinical condition that encompasses defined symptoms, diagnoses, and criteria.

The daily use of madness is to describe a person's unusual mental states and behaviour, and it is often used in public as a denigrating expression. For that matter, the use of madness can therefore be considered a pejorative term for a person or groups of persons. Moreover, the use of madness for this purpose may not only be a linguistic practice that marginalises psychotic patients; it may also be an indication that society in general stigmatises and despises all kinds of psychiatric patients. To prevent such discrimination and to correct the use of the term, patients should live in an empathic environment and feel that they are accepted. Only then can the distinction between insanity and psychosis be made, and meanings can be shaped according to social usage. In conclusion, changing the intended use of the term 'insanity' is a necessary step for the social life and social adaptation of psychiatric disorders, especially psychosis.

As a result, different diseases and conditions are confused with psychosis. However, these may cause both aggressive reactions of the patient in the community and may lead to confusion, as well as delaying the understanding of the disease and thus preventing early diagnosis and treatment. In addition, the confused conditions may sometimes be accompanied by psychosis, as in delirium. Both the population and

scientists should be aware of this difference—according to their own state of knowledge—so that immediate and effective treatment can be provided. In addition, in this way, a humanitarian dialogue can be opened in society with patients with psychosis. In the next section, a brief history of psychosis will be described, and the connection between this and the emergence of the basic perspective used in treatment will be established. Thus, the evolutionary aspect of the approach to the diagnosis and treatment of the disease will become observable.

CHAPTER 3

HISTORY OF MODERN PSYCHIATRY

3.1. 17th-18th Century: Primitive Psychiatry

The aim of this chapter is to provide brief information about the purpose of psychiatry, the history of psychosis, and paradigm shifts in psychiatry. Psychiatry has experienced a contentious process within itself, and different views have been competing against each other. In time these competitions formed paradigms. Thanks to these paradigms, attempts have been made to understand the psychological states of individuals. Thus, the perspectives and views that are effective in the evaluation of disorders and patients have developed under the influence of science and philosophy over time.

First of all, in the past, different cultures, civilisations, and nationalities have made progress in the understanding and treatment of psychiatric diseases at various periods, leading to improvements and developments. For example, the Middle Ages was a period when psychosis was a unique condition and psychiatric patients, especially psychotic patients, were treated as either devils or saints (Koenig, 2020). Alternatively, the Golden Age, also known as the Golden Age of the East, was a period in which psychiatric patients were offered non-scientific methods in line with moral treatment, and their humanitarian and spiritual aspects were emphasised (Dols, 1987). Also other studies were conducted in this period were used in later periods and were thought to play an active role in shaping the dominant canon of knowledge in Europe in the future (Mitha, 2020).

After these researchs there can be said that all of the previous studies made an active contribution to the emergence of psychiatry as a science in the 18th century.

For that time, Philippe Pinel's Medico-Philosophical Treatise on Mental Alienation, published in 1801, made an important contribution to the field of psychiatry (Kendler, 2020). So, Philippe Pinel is a French physician who lived in the 18th century and is considered one of the pioneers of modern psychiatry as him. Pinel stood out in this field because he advocated the treatment of mentally ill patients under humane conditions. Moreover, Pinel's approach made a great contribution to the development of psychiatry by emphasising observation and humane treatment in the treatment of mental illness. His 1801 study also consisted of clinical observations, and the aim of the study was to try to make a systematic classification of mental disorders and to investigate their possible etiological causes. Therefore, a treatment plan was designed with the moral therapy method for Kendler. Hence Pinel's moral therapy was a method specially designed to teach empathic approaches to patients and was one of the first of its era.

Although Pinel's time was pioneering in terms of psychiatry, like previous periods, it also highlighted some problems such as social awareness of mental illness, undertreatment, or lack of human understanding. For example, according to Kroll and Bachrach, mental illness was perceived as a source of shame in society, as it was perceived as a moral deficiency or personal flaw and for this reason, families tended to hide defective family members (1984). Another social attitude, which was also observed in the 17th and 18th centuries, was the belief that mentally ill people were immoral for Kroll and Bachrach. However in reality, patients suffering from psychotic episodes or epileptic seizures did not behave in this way to seduce others. Yet, people migth accused them of moral incompetence and even saw them as having the weaknesses of being human. Therefore, there was a great observable anger and hatred towards the mentally ill.

For these reasons, in such a society and period, Pinel's moral therapy was seen as groundbreaking because it included elements of compassion, empathy, and respect. The changes introduced by him represented a significant shift towards a more compassionate and psychologically informed understanding of mental illness and laid the foundation for contemporary psychiatric methodology, emphasising some of the humanistic imperatives for Kendler. Ultimately, Pinel's work resulted in the emergence

of ‘moral treatment,’ a groundbreaking approach that transformed the fields of psychology and psychiatry, with many positive and constructive effects.

It also had close links with other fields in that it encouraged the prioritisation of compassion, empathy, and respect over traditional approaches based on force and physical restraint in the treatment of people with mental illness. Also, Philippe Pinel introduced an empathic and person-centred approach, still this may not only show that Pinel’s influence encouraged a long-lasting change in psychiatric care and treatment methods, but also demonstrate the need for philosophical roots for humanitarian approaches. In line with this claim, it has already been stated in the literature that Pinel’s sphere of influence was not only psychiatry. For example, the German philosopher George Wilhelm Friedrich Hegel was positively influenced by Pinel’s empathic approach and moral treatment and held Pinel in high esteem (Fountoulakis & Fountoulakis, 2022). As a result, the interaction between psychiatry and philosophy perhaps began earlier than expected and for humanitarian elements.

> ”Will he be able to follow all the variations and distortions in the working of human understanding if he has not meditated deeply over the writings of Locke and Condillac and has not familiarised himself with their teaching (Pinel, 2008, as cited in Kendler, 2020).”

Again, as he makes clear in his discussion and quotation from Pinel, the empiricist approaches of famous philosophers can be used as a fundamental source for understanding human beings. Because only in such a way can psychological processes and psychiatric illnesses be fully analysed.

For this manner, recommended analy- ses can be tailored to the individual and the situation in a scientific, humanitarian and philosophical way and can be effective. Similarly, Alexander Crichton, inspired by Jean-Jacques Rousseau’s views, argued that his Psychopathology of the Passions brought an empathic and person-centred approach to the mentally ill and that this approach should also be within philosophy and psychology (Morris, 1991). Con- sequently Pinel’s work will recognise that the prominence of philosophy and psy- chology in the 17th and 18th centuries ushered in a new era in the understanding of psychiatric problems.

3.2. 19th Century: The Rise of a Psychiatry: Psychiatry Becoming a Medical Discipline

The 19th century was a period of scientific development of psychiatry. In contrast to the previous emphasis on philosophy and psychology, psychiatry adopted a scientific orientation.

Firstly, according to Bynum, some historians prefer the words medicalisation and psychiatrization to describe and understand the history of medicine in the 19th century because psychiatrization began with the mad doctors in the first half of the 19th century (since psychiatry and psychiatrists had not yet been invented) (2003). Therefore, according to many historians, the 19th century corresponds to the period that witnessed the emergence of psychiatry. One of the most important reasons for this is that the classification of diseases, which had begun in previous periods, began to be examined systematically and on a biological basis. Jean-Baptiste Pussin, one of the names influenced by Philippe Pinel, advocated the progress of medicine with meticulous observation and concrete evidence and formulated the theory of ethical treatment using empirical methodology (Schuster, et al. 2011). Indeed Schuster claimed that Pussin adopted this method because he thought that the sterile approach to understanding psychiatric illnesses was hidden in science.

However, these studies should not be seen as the end of moral treatment. On the contrary, it was continued by Pinel's student Jean Etienne Dominique Esquirol (Vardhan, 2011). Dominique Esquirol was one of the most important psychiatrists of his time and used the term monomania for the first time, saying that insanity could be of different types but that instability would only occur in certain areas (Bynum, 2003). In this way, insanity began to be differentiated from other complex and unstable states.

Therefore all these studies and efforts began to be seen not only in Philippe Pinel's country, France, but also in other European countries. For example, Pichot cites William Tuke's construction of The Retreat in the UK as an important development (2009). Similiarly, in Italy, Vincenzo Chiarugi was the leader of the Bonifacio Hospital in Florence, where he pioneered the adoption of compassionate and scientific

methods in the treatment of the mentally ill and advocated for changes in the way people with mental illness are treated and cared for and for him, recovery should be social, not individual (Mora, 1959).

Hence the reforms of Pinel and his followers emphasised the importance of distinguishing between behaviours such as social deviance and nonconformity resulting from mental illness and other forms of social abnormality because the centre of emphasis can be placed on mental alienation. For instance again as Pinel et al., mental alienation was the recognition of the creation of different treatment approaches to address the unique characteristics of the mentally ill (2008). So it may be planned that it was impossible to establish appropriate treatment centres according to the determined definition.

Also, the definition and practical application of mental alienation made it possible to study mental illness in medical institutions and led to the establishment of primitive psychiatric hospitals for them. Hence these units may be tried to better understand the social and medical aspects of mental illness and to establish treatment methodologies and systematic methods.

Also there were a new mental hospitals were built or exist- ing ones were restructured too. For that reason the new system included innovative and transformative features. For example, institutions formerly known as asylums or mental hospitals were created specifically to isolate patients from society and to protect society from the potential harm that patients could cause for Pichot.

Similarly some methods such as torture were commonly used to keep the mentally ill in these institutions too (Elkin, 2017). However, with some regulations, psychiatry could be performed in separate places, and humanitarian and metadological patient care centres were established and mental patients tried to be protected and implemented by laws. For example, the French Statute of 1838 mandated and supported the implementation, operation, and financial support of this new system throughout the Europe (Edington, 2009; Raoult and Harcourt, 2017). Other noteworthy examples in this field may be the enactment of the Asylum Act of 1828 and the Mental Health Act of 1845 in the United Kingdom (Merkulova, 2022).

In conclusion, it suggests that by the end of this century, the theoretical distinction between mental illness and insanity had begun to emerge clearly, and that there were different types of mental illness, which were to be analysed within a scientific and medical framework. As a result, different medical specialities emerged, and mental illness was treated in a specialised manner by specific individuals. Thus, the historical, political, and socio-cultural variables of the period ensured that psychiatry was increasingly seen as a medical field, paving the way for a metadological, systematic, and sterile framework. Finally, these establishments and developments can be considered as a sign of a social evolution rather than being specific to a particular country or culture. Because these developments may indicate that society recognises the importance of public protection as well as the protection of mentally ill individuals and their right to receive appropriate medical treatment. Finally, these organisations and developments can be considered as a sign of a social evolution rather than being specific to a particular country or culture. After that these developments may indicate that society recognises the importance of public protection as well as the protection of mentally ill individuals and their right to receive appropriate medical treatment. Thus, the scientific nature of psychiatry paved the way for an official step towards the diagnosis and treatment of diseases.

3.2.1. Birth of the Diagnosis

In the 19th century, Pinel's humanitarian approach turned the direction of psychiatry towards philosophical points and emphasised the necessity of a humanitarian nature. Affected by that, many people and institutions started to recognise the mental patients socially, publicly or legally by different layers of the society. However, in order to identify and publicise the situation of psychiatric patients, it was necessary to look at the origins of the condition. In addition, the scientific and objective study of psychiatric illnesses was also necessary for the treatment of patients. For these purposes, science - perhaps more than ever - was deemed necessary, and a system was sought to differentiate between illnesses and to understand their developmental process and started the diagnosis in psychiatry.

First of all, it is stated in various sources that the understanding and classification of mental illness has been shaped between medical competence and philosophical re-

search throughout history for Arens, 1996). Likewise, the development of psychiatry, unlike the classification of diseases, requires expertise, proficiency and connections.

Because while the first concept is associated with aetiology , classification is related to nosology. Therefore, the questions of the second part include basic questions such as the relationship between mind and body, typical and atypical biological processes, and the function of the individual in society. Indeed, the first part of the question, on the other hand, involves a multi-layered and difficult process of formally defining invisible psychiatric and psychological conditions as pathological. Because psychiatric illnesses, especially psychosis, have an extremely complex structure, and because psychiatric problems can be relative concepts under different variables such as time, space, culture, gender, etc., it was necessary not to move away from the science of aetiology. Hence, the issue of diagnosis was particularly challenging, given the current difficulties in accurately diagnosing, labelling and treating psychiatric disorders. Moreover, psychiatric disorders lacked the validity and reliability of procedures such as biomarker detection, observation and measurement that were commonly used to identify physiological disorders. In the process, not only was it difficult to distinguish individual differences from patient complaints, but it was also necessary to follow up according to aetiology. Nevertheless, the situation was a knife-edge since human beings are not generalisable like a uniform machines. Therefore, a thorough understanding of the diagnostic and diagnostic procedures used in psychiatry is necessary to be able to treat disorders such as psychosis. For this manner, purpose the work carried out by Esquirol, Pinel and others can be seen as fundamental to the establishment of a scientific basis in psychiatry.

In this sense, as diagnosis and prognosis in psychiatry began with psychosis, the history of modern psychiatry can be considered as the history of psychosis. Because the disorders that Kraepelin tried to differentiate are related to psychosis in today's world. As a result, his studies paved the way for a scientific approach to diagnosis. However, it should not be taken to mean that all problems in psychiatry have been solved, because psychiatric classifications should not be based on a purely biological focus but should consist of diagnoses that have to balance bio-socio-cultural factors. For example, contradictions and conflicts arising from these reasons lead to onto-

epistemological problems in the definition and diagnosis of mental illness (Tekin, 2016).

However, unlike today, it is a fact that psychiatric diagnoses in the past also used studies that emphasised the integration of philosophy and science, and the recognition of mental illnesses as pathophysiological disorders and the application of a methodological strategy based on diagnostic criteria also shows a strong connection with philosophy. In order to understand this connection, it will be sufficient to look at the work of the German neurologist and psychiatrist Wilhelm Griesinger. Griesinger proposed an alternative and holistic framework based on 19th-century German idealism for Arens. In this framework, a conceptual framework for mental illness was attempted, and the main aim was to effectively integrate the scientific framework of psychiatry with philosophy and empirical practice. Mental Pathology and Therapeutics was inspired by Immanuel Kant and Georg W. F. Hegel for Arens and Misharea (1996). In trying to combine Kant's conceptual ideas and Hegel's dialectics with psychiatry, it used a modified version of Hegel's dialectical work on history and science. By seeing the human mind and mental illness as a philosophical and metaphysical construct, he argued that man is not only a biological construct but also a philosophical being. Thus, the advancement of innovative diagnostic techniques in psychiatry has been proposed.

3.2.2. History of Diagnostic and Statistical Manual of Mental Disorders

Another component of the systematic approach to diagnosis was to establish a scientific, international, valid, and reliable diagnostic resource. In that respect, the Diagnostic and Statistical Manual of Mental Disorders (DSM) is one of the most important tools used in the diagnostic process. The DSM was published by the American Psychiatric Association (APA) in 1952 and has been updated with various adaptations over the past periods.

DSM-1: The first version of the DSM included hundreds of different mental disorders. One of the main purposes of the DSM was to develop it for soldiers for the traumas that occurred after the Second World War (WW-II). It was shaped around a psychodynamic element and included general diagnoses (Jackson, 2003).

DSM-2: As Kawa et al, in its second version, amended in 1968, 182 disorders were defined. Unlike DSM-1, the field of definition was widened and included childhood mental problems, personality disorders, and neuroses and tried to distance its language from the psychodynamic structure. Also it had been criticised for evaluating homosexuality under the definition of disease too (2012). Upon the reactions, homosexuality was removed from the DSM in 1973 with the efforts of a group of psychiatrists who called themselves the Young Turks of psychiatry (Glass, 2001).

DSM-3: For Kawa and other researchers, the revision made in 1980 contained the most comprehensive changes in the history of DSM. Firstly, a multi-factorial system was developed to facilitate diagnosis. Accordingly, patients could not only be understood within the definition of disorders, but also different aspects of the disorder could be considered. Thus, disorders were evaluated in 5 axes:

Axis I: Clinical Disorders (e.g., depression, schizophrenia) Axis II: Personality Disorders and Mental Retardation Axis III: Medical Conditions (physiological)

Axis IV: Psychosocial and Environmental Problems

Axis V: General Level of Functioning (social and occupational performance)

As Surís, DSM-3 increased the number of disorders to 265 by adding new disorders not previously included in the manual. The diagnostic criteria were reduced to symptomatology in order to make them objective. Importantly, this was a step towards improving reliability (2016). In this way, personal and cultural differences may tried to be minimised in order to increase inter-rater reliability by different clinicians making the same diagnosis for the same error. On the other hand, the DSM's diagnostic criteria completely and permanently moved away from the psychodynamic model by adopting the biological reductionist biomedical model. Diagnoses and symptoms were based on observable symptoms. As a result, DSM-3 adopted a new system based on the symptom-based biomedical model, which is the mainstream today.

DSM-4: In this revision DSM-III and DSM-III-R was prepared to increase validity and reliability by preserving the basic structures of DSM-III and DSM-III-for Lahey et al., 1990.

DSM-5: This is the last update made in 2013. The multifactorial system was abandoned, and instead a more flexible and permeable method was tried to be taken into consideration. Accordingly, psychopathology was defined by considering psychosocial and environmental factors on the basis of functionality, and individual variables were emphasised. New disorders such as hoarding disorder were added; different diagnoses such as Asperger syndrome and pervasive developmental disorder were combined. Cultural differences were tried to be included in the context by adding the Cultural Formulation Interview. It was aimed to measure the severity of symptoms with the Measurable Symptom Severity Rating. In DSM-5, the biomedical model was not completely abandoned; only the biological justification of etiological causes was expanded, and factors such as genetic and environmental factors were tried to be included. Thus, a holistic view was tried to be provided in diagnosis and treatment (APA, 2013).

Consequently, the concept of mental illness and its treatment methods were first being humanised in the 17th and 18th centuries with the moral therapy of Philippe Pinel. Pinel was not only scientific in his work; inspired by John Locke, Etienne Bonnot de Condillac, and Jean-Jacques Rousseau, he argued that treatments should be human and empirical. Emil Kraepelin was decisive for the 19th and 20th centuries with his division of psychoses into schizophrenia (dementia praecox) and manic-depressive psychosis. Because modern psychiatry was becoming more empirical and scientific, as it had claimed in the previous century. However, this movement and orientation led to the exclusion of philosophical and psychological content. Thus, the differentiation of the basic symptoms of diseases would have begun on the basis of today's psychosis. In other words, the necessary environment was ready for the symptom-based view to emerge thanks to psychosis. This in turn led to the Diagnostic and Statistical Manual of Mental Disorders (DSM), which proposed biological mechanisms of disorders. Hence, the paradigm advocating symptom-centred biological diagnosis and treatment systems began to dominate.

As will be shown in the next section, the view would evolve to a third-person perspective. However, this was not an immediate movement; the biomedical symptom-based model dominated by the third-person perspective developed throughout the evolu-

tion of biological psychiatry. Chapter four will describe the transition of biological psychiatry to the dominant paradigm.

CHAPTER 4

BIOLOGICAL PSYCHIATRY

In previous centuries, there had been a transition from asylums to mental hospitals as facilities for the care and treatment of the mentally ill. Another important development was the development of a diagnostic system. However, all these developments were developments that fed the scientific nature of psychiatry. One of the prominent names in this development was the German psychiatrist Wilhelm Griesinger. Inspired by the philosophies of Hegel and Kant, Griesinger not only tried to comprehensively incorporate the principles of German idealism into psychiatry but also claimed that the aetiology of mental illness could be attributed to cerebral or biological factors for Arens. Also according to him, mental illnesses had specific causes (Griesinger, 1843/1964, pp. 168–172, as cited in Mooij, 2012, p. 20). Although underlying these causes were environmental concepts, the most likely cause of mental illness was biological. In other words, all psychiatric illnesses were biological. Therefore, all mental illnesses were also diseases of the brain (Marx, 1972). Wilhelm Griesinger's attempt to develop psychiatry made an important contribution to the scientific development of psychiatry because he recognised that mental illnesses had a physiological basis and tried to define them as brain disorders. Griesinger also developed a reductionist perspective, although he took into account individual, philosophical, cultural, and historical aspects. Because the main point is biological and other elements are unlikely. However, it should be noted that the perspective here is more moderate than radical reductionism (Griesinger, 1843/1964, pp. 168–172, as cited in Mooij, 2012, p. 20).

As a matter of fact, Griesinger, who claims that mental disorders are reduced to biological factors, is considered the pioneer of biological psychiatry like Arens and Mooij. Due to the methodologies developed and the arguments relied upon, biological psychiatry is very important, as it is the basic foundation on which the biomedical

symptom-based approach, which is the dominant approach today, has been based. In this section, the development process of biological psychiatry will be explained starting from the first stages of its emergence. The initial moderate reductionist attitude will continue as it becomes more and more integrated into the modern and scientific framework. As a result, it will evolve into a biomedical symptom-based model, giving way to radical reductionism.

4.1. The Beginnings of Biological Psychiatry

Germany was a country that made important contributions to the field of thought with the philosophers it produced in the 18th and 19th centuries. Famous philosophers such as Hegel and Kant can make an important contributions to many conceptually difficult-to-understand topics such as metaphysics, reason, and morality, and as mentioned in the previous chapters, they were also associated with psychiatry. However, not only individual contributions but also organisational work was prominent. In the same period, research institutions, universities, and academies were also influenced by such research topics and started to establish centres that tried to reduce prejudices against the mentally ill and tried to prepare an environment where psychiatry was seen as a scientific and separate discipline. For instance according to Rayard, it is stated that the mental hospitals in Germany were no longer just centres that separated the mentally ill from the rest of the population and constantly controlled them, and this was also implemented by various universities (2013). Therefore, Germany was the important centre of psychiatry in practice. In fact, when the famous medical books and medical dictionaries of the 20th century were analysed, it was seen that the term symptom was actually derived from German terminology (Babağ lu, 2002, p. 87). For this reason, Germany was also one of the centres of theory. During that times so, it can be understood from the fact that the terminologies used were in German that this centrality was also accepted by other countries and institutions.

On the other hand, Germany was becoming a bipolarity by hosting different views and claims too. One view was based on science and biology, while others opposed the reductionism of science and emphasised the consideration of moral and ethical aspects. Thus, it continued to contribute to psychiatry as the country of origin of two

opposing views. For instance as the moral and ethical advocates mentioned above believed that patients' mental problems were caused by sin (Mora, 2008). According to them, psychiatry was intertwined with the concept of morality and moral philosophy. As Ellenberger, this school of psychiatric thought, which called themselves Physiker, believed that people became ill when they lost contact with their moral and spiritual aspects and argued that these aspects should be healed (p. 61, 1974). Therefore, they might argued that all mental illnesses are related to moral, ethical, and theological concepts and that psychiatry is basically a spiritual and philosophical discipline. In this sense, it was believed that emphasising these elements in the necessary treatment would be possible from the good moral people around them and that psychiatrists would learn by seeing by Marx or Mora. There were also many famous thinkers who favoured this view such as Johann Gottfried Langermann, Johann Heinroth, and Karl Wilhelm Ideler expressed their support in various ways for Mora or Ellenberger (p. 62). However, these arguments and claims were heavily criticised on the grounds that they ignored physical and biological elements, emphasised metaphysical and theological elements, and created opposing alternative views for Pichot (2004). As a result, the second dominant view, the science-only position, became more prominent.

Additionally, in line with the mechanistic worldview of the period, scientific advances were increasing, and advocates of science were becoming increasingly powerful in different disciplines. Hence, psychiatry was advancing as a scientific discipline, and researchers were actively promoting the idea that the brain, rather than moral- ity, should be at the centre of psychiatric illness. One of the most prominent representatives of the claim that psychiatric illness was purely scientific was Wilhelm Griesinger. Griesinger and his supporters believed that all psychiatric illnesses were exclusively brain-centred and were brain diseases for Arens. Moreover, the developmental stages of the biological psychiatry movement, in which biology was seen as the cause of psychiatric illnesses, were not limited to this notion. Even for some sources, Griesinger, who claims that mental disorders are reduced to biological factors, is accepted as the pioneer of biological psychiatry by different sources (Mooji, 2012, Arens, 1996). There was a growing tendency to associate clinical observations made in different people and countries with pathological symptoms. For example, in the same period, French physician Bénédict Augustin Morel's theory of degener-

ation strengthened the medical position of psychiatry by establishing a link between the hereditary transmission of mental disorders and the harmful influence of environmental factors (Carlson, 1985). In his opinion, mental and physical problems were genetically transmitted to future generations. Following his point of view, psychiatric illnesses were not individual but were inherited and passed on to future generations until the last generation failed to survive and became extinct. Today, although modern genetic studies have disproved this theory, it can be seen as one of the first systematic theories suggesting the interaction of genetics and environment in psychiatric disorders.

The other important figure in the development is Johann Christian Reil, the founder of biological psychiatry. The term psychiatry was introduced by Reil in Germany in 1808 and played an important role in the establishment of psychiatry as a separate and special medical speciality (Binder et al., 2007;). In this respect, there was a departure from the Physikers, a group of well-known German psychiatrists such as Johann Gottfried Langermann, Johann Heinroth, and Karl Wilhelm Ideler for Ellenberger. Moreover, according to the article's author, the cause of all illnesses, including mental disorders, could not be distinguished merely by looking at specific concepts. Instead, he argued that these concepts interacted with each other in a way that was too intense and complex to be restricted to names such as physiological, biological, and psychological. Thus, Reil's position paved the way for biological integrative approaches to the aetiology of mental illness. Reil has also advocated medication or pharmacological methods and surgical interventions for psychosomatic illnesses but also suggested psychic therapy as an alternative (Binder et al., 2007). It can be considered similar to primitive psychotherapy because the practice was developed to better understand mind-body connections. So, all these efforts of Johann Christian Reil should not lead to the perception that he had a romantic attitude, but instead these efforts were one of the key concepts used to understand mental processes in the brain.

Finally, Reil's work on early psychopharmacological studies was seen as an important part of psychiatry. In his view, drugs should be used in the treatment of psychiatric disorders (Weber and Emrich, 1988). According to his opinion and claim, psychiatric disorders are purely biological. It shows that he aimed at internal, bodily recovery.

The patient whose brain and body were healed would have no reason to be ill. As a result, Germany became the centre of biological psychiatry. Although this view started out as a moderate reductionism, it became more rigid and radicalised in the face of the romanticised understanding of psychiatry, which emphasised ethical and moral elements. Wilhelm Griesinger was one of the pioneers of this movement. Johann Christian Reil was one of the leading figures who, thanks to the sterility and restraint of science, brought psychiatry to a scientific position and ensured its formal separation.

Both names and their followers enabled psychiatry to move within the mantle of science, and in this line, both clinical and practical practitioners became one of its practitioners, and biological psychiatry proved its strength. Thus, biological psychiatry is of great importance as the basis on which the biomedical symptom-based approach, which is the dominant model today, is based. Because this view has become the dominant view with the development of science and technology.

4.2. 2nd Wave of Biological Psycihatry

Biological psychiatry emerged in Germany and was based on neurobiological, genetic and biochemical approaches to the understanding, diagnosis and treatment of mental illness. Biological explanations were therefore increasingly accepted as a new centre of focus in the explanation of psychiatric disorders. Especially these developments gained momentum in the second half of the 20th century. After the birth of this view, the developments made in this context can be ob- served in the second wave, which is the development process. Especially these developments gained momentum in the second half of the 20th century.

4.2.1. Psychopharmacological Developments

While the establishment of biological psychiatry is considered to be the first wave, its development was part of another. The second wave was a period in which biological claims were strengthened by developments, and the effects of drugs on people and their behaviour were proven. Some of these developments will be described in the following section.

Firstly, according to Brownstein, some types of psychotropic drugs, including opiates and their sources, have been used on the mentally ill since ancient times, including Ancient Greece, for their sedative effects (1993). In this respect, the use of pharmacological aids could provide insights that may not be as ancient as one might think. Moreover, the use of pharmacological aids became widespread in the 1960s, especially with the rise of psychopharmacology, and made significant advances with the discovery of drugs used in psychiatry (Walter, 2013). In fact, according to Walter, the most important example of this was the identification of powerful drugs such as lithium in 1949, chlorpromazine in 1952, imipramine in 1957, haloperidol in 1958, and diazepam in 1963. As a result, these drugs became a source of help for many disorders, especially psychotic disorders, which are complex in nature and difficult to experience. In the mid-19th and early 20th centuries, dozens of drugs and their active ingredients were discovered. This scale was expanded in the 1950s with the discovery of the effects of chlorpromazine and the addition of synthetic drugs such as bromides, barbiturates, and amphetamin (Rasmussen, 2006). Furthermore, the discovery of chlorpromazine in the 1950s was seen as another important milestone. According to Boyd-Kimball et al., this discovery had a profound impact on the medical treatment of complex psychotic patients such as those with schizophrenia and greatly accelerated progress in psychopharmacology (2018).

As the emergence of contemporary psychopharmacology as a result of all these developments resulted in a therapeutic revolution in psychiatry and strong support for the biological perspective, biological psychiatry became the source and support centre for the resulting drug developments and uses. In this way, psychopharmacology became an important resource for the treatment of mood and psychotic disorders. Again, especially the treatment of schizophrenia and bipolar gained momentum. For example, for schizophrenia, it formed the basis for the development of antipsychotic drugs targeting specific neurotransmitters in the brain). Similarly, the use of lithium salts in the manic treatment of bipolar patients was seen as promising and consistent application of salts was accepted as an effective method in mood disorders (Tondo et al., 2019). As a result, all these developments had important effects and consequences for the field of psychosis. These substances and drugs were recognised as having therapeutic benefits in the treatment of various mood disorders such as paranoid, manic, and

depressive episodes, and human interaction with drugs increased further. Thus, the development of psychopharmacology strengthened the field of biological psychiatry and secured its dominance in the field.

4.2.2. The Rise of Neuropsychiatry and Neurology

At that time, the human brain was being studied in a very important way. In the twentieth century, these studies led to the strengthening of the field of neuropsychiatry and the modular study of mental illness. This process can be understood by looking at the history of neuropsychiatry and neurology. In the beginning, these fields were not different from each other; both of them studied the human brain in medicine. Neurology emerged in the 17th century, and Moritz Heinrich Romberg made an important contribution (Housman et al., 2014). According to them, he also made significant contributions to the study and treatment of diseases affecting the nervous system.

Furthermore, the comprehensive systematisation and standardised methodology presented in the book had a significant impact on the field of neurology and enabled neurology to be evaluated from a third perspective. Later, in the middle of the 20th century, the changing political situation caused German doctors to move to other countries. In this way, neurology spread to other countries through the German school, and studies on brain diseases increased. Thus, other countries began to study the brain and its processes from an objective point of view. Neurology, a special field of medicine, emerged as a separate field of study in the early 19th century. It focuses on the research and treatment of disorders affecting the brain, spinal cord, and nervous system. Throughout the 20th century, increasing emphasis has been placed on conducting research, adopting systematic methodologies, and applying scientific perspectives to the study of the nervous system. These efforts have played an important role in strengthening the foundation of current neurological practice. Undoubtedly, neurology alone is not a comprehensive field. Despite its ancient origins, neurology differs from psychiatry in its emphasis on scientific research in neuroanatomy and neurophysiology (Cowan & Kandel, 2001). Thus, the differentiation between the disciplines of neurology and psychiatry, which overlap in some areas as mentioned earlier, has emerged as a result of the increasing demand for comprehensive knowledge

and specialised skills in the diagnosis and treatment of neurological disorders. Therefore, the emergence of neuropsychiatry and neurology has offered the potential to link neurology and psychiatry to better understand and more effectively treat disorders involving both the brain and the mind. Today, there is evidence to support the idea that psychiatric disorders are in fact diseases of the brain. Such a view is consistent with the biomedical model that was widely accepted in the second wave. This is because similar issues and solutions were discussed and defended. Thus, neurology and psychiatry were closely linked, and biological psychiatry became more important with the emergence of neuropsychology. Therefore, in this period, the biomedical model, which perceived the body as a mechanical system and emphasised the examination of individual body parts rather than a holistic approach, came to the fore in neurological and neuropsychiatric research. As a result, the second wave of biological psychiatry would gain more support as its field expanded.

The discoveries made during this period, in addition to supporting this claim, introduced many methodologies for understanding and combating mental illness and intensified the need to understand the impact of brain activity on mental well-being. In this context, Hans Berger's (1920) description of electroencephalography (EEG) can be said to be an important development. Berger pioneered the electroencephalography (EEG) technique and successfully captured brain waves. The research conducted by Da Silva represents a significant advance in the field of epilepsy and other diseases related to brain activity (2003). Shortly after, Ugo Cerletti and Lucio Bini discovered electroconvulsive therapy (ECT) in the 1930s as a means to treat seizures in individuals with epilepsy (Gazdag and Ungvari, 2019). Furthermore, these studies have been used in the treatment of depression and psychotic patients and have continued to be used ever since. It has also been shown that some brain damage can cause difficulties in language, memory, perception, and other cognitive functions.

The aim of this research will be to examine the neurological basis of psychiatric disorders and to develop the links between the identification and treatment of psychiatric disorders that form the basis of neuropsychiatry. It emphasised one of the main goals of the biomedical model. Because the current biomedical paradigm also tries to handle psychoneurological discoveries related to various mental illnesses in different

ways. A comprehensive understanding of the historical progress and interconnection between neuropsychiatry and neurology is therefore of great importance for the future of German biological psychiatry and the biomedical model. Indeed, as this relationship strengthens, the field of neuropsychiatry can make progress in the treatment of conditions that involve both neurological and psychiatric symptoms, such as neurodegenerative diseases, epilepsy, and mood disorders. These advances have also paved the way for the development of the biomedical model.

4.2.3. Development of Brain Imaging Techniques

As can be seen from the previous sections, as the field of second-wave biological psychiatry expanded, it began to gain more and more momentum. This support came not only from pharmaceutical companies, chemists, or neurologists but also from advances in technology, which led to the development of equipment and techniques to enhance this emphasis. The second wave of biological psychiatry saw many developments in this context.

Firstly, technological developments intensified the need to understand mental illness, to propose many new methods for treatment, and to understand the impact of brain activity on mental well-being. Hans Berger's description of electroencephalography (EEG) was revolutionary in 1920 (Hass, 2003). As Haas, Berger proposed the relationship between brain activity and mood by successfully capturing waves in the brain with the electroencephalography (EEG) technique. This method was also very useful and successful in the field of psychiatry. For example, a correlation between epilepsy and brain activity can be recognised by EEG, thus facilitating the understanding of neurological and psychiatric diseases. Similarly, the brain and its electronics were ripe for further development: In the 1930s, Ugo Cerletti and Lucio Bini used electroconvulsive therapy to treat seizures in epilepsy patients as Gazdag and Ungvari. With this method, two invisible phenomena, electricity and epilepsy, were brought together, and other possibilities were shown to be possible. In this way, brain imaging techniques continued to develop and were tested on psychiatric diseases and became widespread. For example, EEG and ECT are still being used in suicidal, psychotic patients with major depressive episodes.

Biological psychiatry has also given importance to the development of brain imaging tools and methods and has associated the psychoneurological connections of various mental illnesses with neurology and recommended drug treatment. As this link has strengthened, the field of neuropsychiatry has made advances in the treatment of cases with both neurological and psychiatric symptoms, such as neurodegenerative diseases, epilepsy, and mood disorders. These advances will pave the way for the third wave of biological psychology in the future, the biomedical model.

4.3. 3rd Way of Biological Psychiatry: Biomedical Symptoms-Based Paradigm in Psychiatry

Biological psychiatry, which was born with a focus on science in previous periods and developed with different fields, became more mechanistic and positivist in the modern process (Double, 2005; Kendler, 2008). However, in the spirit of the period, it became sophisticated and symptom-orientated, increased its systematicity, and evolved into a symptom-based model. In this section, this transformation will be examined in the third and last wave of biological psychiatry. The biomedical symptom-based model is the dominant model in which biological psychiatry developed, focusing on the observable behaviours and symptoms of individuals and defining and classifying them in this context. For this reason, it is currently criticised for being impersonal and excluding subjective experiences and structures. Although it is the dominant paradigm, alternative models and approaches have been put forward. Despite these, it is still preferred because it is cheap, easily accessible, scientifically realistic, and easy to train.

4.4. Biomedical Symptom Based Model

4.4.1. Reductionist Approach

The biomedical symptom-based model focuses on neurobiological factors and observable symptoms. This way, it distinguishes and categorises complex and dynamic psychiatric disorders by reducing them to measurable symptoms. Diagnosis is based on the ontology of specific sets of these symptoms. In other words, the presence or

absence of disorders is based on these clusters. Thus, the biomedical symptom-based approach proceeds in accordance with a third-person perspective. Moreover, since the model is observable, symptom-orientated, and biologically based, it can be said to be along materialist reductionist lines.

4.4.2. Standardisation

The biomedically based model categorises diseases and symptoms in distinct ways and therefore relies on standardised diagnostic criteria, the most important of which are the DSM and ICD. Standardised approaches thus aim to ensure that the same patients receive the same diagnosis at different times, in different places, from different specialists, or that people diagnosed with the same disease receive the same treatment. Thus, the dominant paradigm aims to ensure consistency in validity and reliability by providing an objective or third-person perspective.

4.4.3. Emphasis on Biological Causality:

The dominant paradigm places strong emphasis in its manifestos on biological and neurobiochemical imbalances as the cause of disease. In this way, the references and emphasis break down diseases and their causes into simple components that are objective, measurable, manipulable, and controllable. Thus, the third-person point of view is provided by the reductionist attitudes and methods applied.

4.4.4. Proposed Medication-based Treatment Approach

Treatment is generally based on pharmacological interventions. This is part of the symptom-orientated approach, which acts in a reductionist way. This approach targets the symptoms of patients and attempts to treat them with medication. Hence the method seems to be a purely objective, scientific method and is associated with a third-person point of view.

4.4.5. Emphasis on objectivity, Scientificity and Impartiality

The biomedical symptom-based approach is symptom-based and therefore does not use a method that incorporates personal differences, subjective effects of the disease,

and the patient's experiences during the diagnosis and throughout the treatment. Also, it is compatible with the third-person perspective, as it is an objective and measurable method. However, although the third-person perspective prepares this method for a wide audience, it focuses on the dysfunctional aspect of symptoms, excluding many individual, cultural, gender, linguistic, and social diversities. As a result, the biomedical symptom-based model has been criticised for moving in the direction of the third-person perspective and looking at observable notions and not adequately addressing the complex interaction of fluid phenomenological-psycho-socio-cultural and environmental variables.

4.4.6. Symptom-Based Model

The biomedical septome-based model aims to understand psychiatric disorders through their bio-neurological origins, as suggested by biological psychiatry (DSM, 2013). It is also based on observable behaviours and symptoms of individuals. Patients applied to the specialist with the complaints they experienced, and these complaints were evaluated within a certain pattern. The purpose of all this is to ensure that the specialist acts from a third-person perspective within the scope of the most objective, measurable, observable, and objective findings. Therefore, symptom-orientated interventions and treatments have been developed, and diseases have been standardised by placing them in a certain framework and meaning. The developed symptom-based approach is particularly important in psychotic illnesses because each illness has its own highly subjective and experiential nature. This is difficult to differentiate, which makes scientific diagnosis and treatment difficult under normal circumstances. The symptom-based approach can therefore be considered valid and reliable.

4.4.7. Standardised Diagnostic Systems

As seen in the 19th century with the emergence of diagnostic systems, it was essential for diagnostic systems to be scientific and objective in order to ensure validity and reliability. For this understanding, agreed diagnostic systems such as DSM (Diagnostic and Statistical Manual of Mental Disorders) could be taken as a basis. In this way, psychiatric disorders could be classified, categorised, and updated with scientific

data and clinical observations in different places, times, and conditions. In addition, while biological psychiatry emphasised the use of neurological and scientific tools such as brain imaging techniques and genetics, the symptom-based paradigm had clinical observation, observable symptoms, and standardised diagnostic criteria. In addition, the biomedical symptom-based attitude was to aim for a treatment modality in which symptoms were treated. This is because it focused on antipsychotics and antidepressants developed in previous years (Pereira and Hiroaki-Sato, 2018). However, biological psychiatry cannot focus on symptoms because it examines neurobiological concepts in detail in terms of causality. In addition, the model seems to be individualizable as the treatment uses the patient's biological history and observable symptoms. Because the subjective symptoms of patients are tried to be systematised. Thus, in contrast to biological psychiatry, this paradigm tries to provide a broader framework based not only on biological foundations but also on measurable symptoms and clinical practice. Again, it builds on the objectivity claims of biological psychiatry without completely moving away from its origins. In particular, the standardisation and scientific justification of symptoms have made the third wave an integral part of modern psychiatric practice.

In summary, the claims of the Biomedical Symptom-Based Model are as follows:

1. All psychiatric illnesses can be causally linked to abnormalities in brain structure or imbalances in neurotransmitters, and thus their biological origins can be causalized.
2. Since the biological basis of all psychiatric illnesses is accepted, the brain is bio- logically treatable. The treatment therefore follows the same logic as the treatment of physical illnesses.
3. Observable complaints and symptoms of the patient are added to specific frames and diagnostic systems, such as the DSM, which are systematised.

4. Alternative methods outside the model have poor validity and reliability because they often lack scientific validity and reliability.

In summary, biological psychiatry is a view based on the biological basis and the brain, which emerged in Germany in reaction to the view that psychiatric disorders

are caused by the lack of moral and religious concepts. According to this view, all psychiatric problems have a neuro-bio-physiological basis. It uses genetic and biological studies and brain imaging techniques to strengthen these claims. The most obvious point where it differs from the biomedical symptom-based model is that it develops treatments centred on the underlying biological causes and processes. The biomedical symptom-based model is the result of the scientific, philosophical, and technological evolution of biological psychiatry. In contrast to biological psychiatry, the view of the patient and illness has been seen as radically reductionist as it is handled in a positivist, mechanistic process.

4.5. Criticism of the Biomedical Symptom Based Model in the Philosophy of Psychiatry

The biomedical paradigm is a model that has made numerous contributions to both the health system and society. The concept, derived from biological psychiatry, has made significant advances in alleviating the negative effects and social burden of mental illness. Biological psychiatry, based on genetic and biological origins, adopted systematic resources such as DSM, brain imaging and pharmacological methods over time. Thus, following the basic view of the third- person perspective, it began to apply systematic treatment and diagnoses with more objective and more scientific explanations. In particular, thanks to the advancement of the scientific knowledge mentioned above, public bodies began to provide quick solutions to the needs of individuals. Despite the severe con- sequences of complex illnesses such as psychosis, the aim was to maintain the functionality of patients. This goal was to be made possible by the psychopharmacological resources available to clinicians; the management of disorders such as mania and depression was planned (Sadock & Sadock, 2010, pp. 507–510). Therefore, the biomedical model offers an advantageous treatment model at both individual, social and public levels. As a result, the biomedical model, which reduces biological causality to sepmtom in the origin and treatment of mental disorders and focuses on solving them with medication, has gained strength in psychiatry and has been universally accepted (Deacon, 2013). As a result, biomedical symptomatology is a medical field that aims for scientific certainty in the process of diagnosis and treatment of mental disorders in the light of observable behavioural

outputs, verbal reports of patients and their relatives and the expert's own insight. Even if validity and reliability, which are the criteria, are maintained and sustained from a third-party perspective, the failure to take into account the geno-cultural structure sufficiently, the exclusion of subjectivity and experience, the mechanisation of the treatment process in a uniform way and the detachment from the content of the patient and the disease can be presented as serious criticisms in the context of the philosophy of psychiatry. These criticisms can be particularly pronounced in cases such as psychotic disorders, where the subjective, phenomenological perspective and experience of patients is involved.

4.5.1. Socio-cultural Elimination

As a practical consequence of the fact that people today receive psychiatric diagnosis much more quickly and simply thanks to the biomedical symptom-based approach compared to the past years, misdiagnosis and treatment rates may increase. However, there are also many disadvantages. First of all, the diagnostic resources of the biomedical symptom-based model, in which disorders are systematically characterised, tend to consider conditions that were not previously accepted as diseases or problems as disorders. For example, according to DSM-5, if an individual is in a grief process exceeding 12 months, this is called prolonged grief disorder. This is limited to six months in young people and adults. There are different criteria such as intense stress and pain experienced by the person after the loss of a loved one, inability to fulfil personal functions (Eisma, 2023). However, the reactions to the loss of a loved one are quite human, such as unpredictable emotions, vulnerability and fragility in the face of death. The DSM has been highly criticised for standardising a person's cultural, familial, individual and social dynamics and limiting emotional reactions and processes in certain ways and durations. Similarly, Premenstural Dysrophic Disorder (PMDD) is another controversial condition. PMDD can be associated with the presence of at least 5 of the following conditions in the last week in women in utero pessimism, depressed mood, marked increase in interpersonal conflict, sudden anger and tearfulness, as well as personal restlessness, moodiness, lethargy, impaired concentration, increased sleep, swelling and tenderness of the joints, especially the breasts (Sundström-Poromaa and Comasco, 2023). However, these subjective assessments

can be evaluated in a perspective that does not include the person's daily life pace and concepts that include direct environmental factors such as stress. Because all these situations are taken out of context and attributed to the so-called hormonal imbalances of individuals with a uterus. This can be expressed as sexism dressed up as science. As a result, the intervention of science into the body and emotions of human beings with a sexist and authoritarian dictum is immoral in a world that seeks validity and reliability. As can be seen, it is a problem that the biomedical symptom-based model acts in this way and draws a picture abstracted from content, personal characteristics, socio-cultural structures and limited to certain patterns. Moreover, according to the model, the organic and inorganic connection of the individual with the society - and its units - causes him/her to be seen as sick or healthy by labelling him/her as normal or abnormal. This is highly restrictive and even pruning. Because by excluding personal and human elements, colourless and flat definitions can be arrived at. What is recognised as abnormal in some cultures, times or situations may be seen as normal in others (or vice versa). All these definitions, then, are highly fluid according to context.

For example, societies of the time believed that epilepsy patients living in ancient times were possessed by the devil/evil spirit, schizophrenia patients communicated with demons, and psychotic post partum experience experienced by women who had just given birth. Similarly, the belief that an evil spirit called Albastı is haunted by a malevolent spirit is a figure encountered in Central Asta and Anatolian cultures. While these examples can be evaluated at a naive level among the people, there are also examples that directly concern DSM and psychiatry. For example, the psychiatric disorder defined as Dissociative Identity Disorder in DSM-5 should be discussed in philosophy and psychology with its controversial nature. Multiple personality disorder (dissociative identity disorder) is a condition in which a person has and claims to have two or more personality states in the same body and is often associated with traumas experienced in early childhood (APA, 2013). Like Ian Hacking explains the concept of the loop effect, psychiatric illnesses, including DID, are reinterpreted and evaluated not only individually but also in the socio-cultural context of society (Tsou, 2007). This evaluation affects not only the individual lives of patients, but also their interpersonal lives. Thus, there is a relationship between the diagnosis of the special-

ist and the patient, but also with society. The frequent media and cultural coverage of DID or schizophrenia is an example of this circular relationship.

In addition, as noted, there is another controversial status of DID. This can be attributed to the lack of diagnostic validity and reliability and the effects of socio-cultural structure. There are no objective, third-party, reliable sources to explain and diagnose DID, and the diagnosis is based entirely on subjective interpretation and judgement according to Western European-North American scientific cultural attitudes. In some cases, this may lead to misdiagnosis of DID, or it may be claimed that DID was inadvertently created during therapeutic interventions. The creation process explained within the scope of iatrogenic effect can be explained as side effects or undesirable situations that may arise as a result of the treatment applied by the intervening psychiatrist. During the therapy process, the psychiatrist may ask questions implying that the patient has more than one identity and that these are divided, and may reveal observable symptoms by using manipulative language. Although the problem here is seen as the manipulative attitude of the clinician or the subjective-objective content conflict, the DSM proposes a western interpretation and attitude by ignoring certain cultures. This results in the sanctification and rewarding of the culture that accepts objectivity and third-person perspective as the basic concept. It also shows that the visible/observable symptoms that the biomedical symptom-based approach relies on to be reliable and valid can in fact be manipulated by individuals and organisations.

Thus, it shows that the dominant model's attempt to be scientific and objective can in fact be directly or indirectly influenced by certain cultures, situations, languages, religions or structures influencing individuals and their subjective and objective definition. These are some of the limitations that the biomedical symptom-based approach ignores or opposes.

4.5.2. Exclusion of Subjectivity, Experience and Meaning

The effort of the biomedical symptom-based model to explain the objective, measurable concepts in the treatment and diagnosis process of psychiatric disorders with bio-

logical foundations and to reduce them to neurological causes has been mentioned before. The main motivation of this attitude was the goal of finding permanent and systematic solutions to diseases by staying within the certainty of the scientific method (and trying to create this certainty). However, another problem with this approach is that it has a uniform structure that leads to the loss of the patient's subjectivity, experience, and personal meaning. This uniformity prunes the subjectivity, experience, and meaning of the person and excludes their individuality. However, this is a contradiction in terms of psychiatric illnesses (especially psychosis), where the phenomenality of the person is that of the patient.

Although psychiatry is a field of medicine that aims at scientific certainty and bases it on biological foundations, this field has formed its building blocks in a different way from other medical fields. These are the lack of precise biological markers for diseases and the fact that diseases are caused by things that are invisible to the eye. Therefore, the syndromes and diseases treated—even though they involve observable explanations and conditions—involve the effects or consequences of invisible phenomena. Depression, for example, is a condition explained by biochemical imbalances for the biomedical neighbourhood-based paradigm, and in this context, drug treatment is prioritised (APA, 2013).

> "When I was 17 years old, I experienced such intense depression that it felt as if a huge hole had opened up in my chest. Everywhere I went, the black hole followed me. to. So to address the black-hole issue, my parents took me to a psychiatrist at Johns Hopkins Hospital. She did an evaluation and then told me this" The problem with you," she explained, "is that you have a chemical imbalance." It's biological, like diabetes, but it's in your brain. The level of a chemical in your brain known as serotonin is too low. This chemical imbalance is caused by a deficiency in serotonin. imbalance. We need to give you medication to correct that." Then she handed my mother a prescription for Prozac" (Hamilton, 2012, para, 1).

As can be seen, in this case, how the person experiences an event, the internal and external resources that he/she uses or does not use or cannot use in the process of experiencing, his/her own access to these resources... in other words, his/her subjectivity and personal meaning world must be included in the process. This is essential for understanding the patient and the illness. Depression and grief, for example, are

very normal and expected reactions to an accident or natural disaster in which a person has lost all family members. The person may not feel well for six months. But this will be labelled as prolonged grief disorder in the DSM-5 criteria. But is this really a disease?

Perhaps the problem and morbid thinking here is that life experiences and the meaning of the individual are actually dissolved in the scientific sterility imposed by the dominant model. On top of this, another problem is the subjectivity of the symptoms; that is, their onto-epistemological access is only open to the patient himself/herself. This so-called privilege of epistemic access by Michael Paunen; it is not considered sufficient for patients with the disease but rather attributes it to the expert, thus creating a situation in which the person themselves is not seen but also ensuring that treatment is—by its very nature (2012) . Hence it is particularly problematic in psychosis because what makes the illness special is that the patient is sometimes unable to explain themselves to the specialist or others, or even to fully understand himself/herself. Therefore, there is limited access for the patient, relatives, and the expert.

> "...CAN I ever forget that I am schizophrenic? I am isolated and I am alone. I am never real. I play-act my life, touching and feeling only shadows. My heart and soul are touched, but the feelings remain locked away, festering inside me because they cannot find expression...Can I ever forget that I am schizophrenic? I am a ghost within myself, a spirit no one knows...What good is physical freedom if the human feelings are trapped, unable to escape? I am in my own prison. I feel like I'm just stumbling around, grasping at straws hoping one will be the key to open my heart. It never comes, and I wonder if I'll ever give up ...Life for most schizophrenics is a nightmare full of fears and doubts about oneself and about reality; they have a distorted view of that most profound question of how they relate to the world around them. Boundaries become unclear and other people are frightening and not to be trusted. Thus, the very thing which could bring relief - closeness to other people - is shunned as something horrible and dangerous... (Goleman, 1986)".

In addition, the symptoms on which the DSM is based are categorised along male, middle-aged, heterosexual, white, middle-class, Western European-North American lines, far from personalisation, and the rest are pruned and discarded (Gupta, 2019). However, psychiatric disorders such as psychosis have a dynamic and fluid structure. This results in variable symptoms that occur both in the person and over the course of the illness. This may lead to misdiagnosis or late diagnosis of psychosis. Moreover,

while early diagnosis should be an important threshold in the treatment of psychotics, the world is far from meeting these standards. Again, the treatment provided by the dominant model—even if the diagnosis is correct and early—may not be appropriate for the individual or may be less effective because it does not include the subjective experiences of psychosis.

> "...Many of the symptoms that crippled me for years have come under some control. The totally frustrating part of this illness is that it is always growing, always changing. There are always new symptoms, new fears to conquer. Some- times I get tired, and it is the weariness more than the pain that brings tears to my eyes..Some of the symptoms I experience now are different than when the illness first began but they are just as painful and just as powerful. At times my thinking about things around me becomes confused as is revealed by this entry in my journal: I live in the shade and I try to capture its edge so I can contain it but it keeps growing (Goleman, 1986, para. 4)."

Finally, in some cases, the patient may not be able to adapt to the medication. Even if the expected compliance is achieved, other psychological problems may occur as side effects. These may damage the individual's confidence in the treatment process, and the self-perception of the error may be negatively affected due to reasons such as unsuccessful management of the situations that occur as side effects and the process. Therefore, the patient's phenomenological perspective is neglected, and the treatment is tried to be managed inefficiently.

In conclusion, the current model, which systematises dominant observable criteria and is based on neurobiological causes, does not take into account the subjective experiences and personal meaning worlds of patients in both diagnosis and treatment. The model fails to be inclusive as it is designed to suppress only certain types of symptoms in a certain class of people. Thus, the patient is alienated from his/her own treatment process. As a result, the patient is alienated from their own treatment process, which leads to many important problems for the patient and their relatives.

4.5.3. Mechanical and Uniform Treatment Due to Failure to Evaluate Content

The main goal of psychopharmacological drugs used in the model is to eliminate complaints and symptoms by correcting neurotransmitter imbalances that lead to psy-

chiatric disorders. Because, according to basic assumptions, drugs are designed to completely cure biological problems and eliminate symptoms. However, to date, no conclusive evidence or biomarkers have been found to support the idea that mental illnesses are caused solely by neurobiochemical abnormalities in the brain (Kendler, 2024). Therefore, other underlying bio-psychological causes or symptoms may be suppressed by medication and may be overlooked.

As can be seen, psychiatric disorders such as psychosis are not only caused by specific neurotransmitter imbalances. This shows that the diagnosis and treatment process requires more than drug therapies designed for a specific group, age, gender, sexual orientation, culture, and genetic structure; it requires a nuanced and human approach. In order to achieve this, it is essential to ensure the active participation of the patient. However, the dominant model is expert-centred; the expert asks the patient certain types of questions and tries to discipline the patient by creating a hierarchical and authoritarian atmosphere in communication. Although the authoritarian and sterile environment created is necessary to prevent chaos in the hospital, it may trigger traumatised patients. In addition, according to a study, it was observed that clinicians fear and avoid their psychotic patients (Tidefors & Olin, 2011). Similarly, it has been observed that this authoritarian situation does not escape the attention of patients and that they feel invisible or insignificant because their questions to the experts are not answered (Villalona, et al., 2020). In addition, it is among the other findings that these behaviours of the experts are cross-cultural. Therefore, a method that supports an empathic and humanistic dialogue, ensures the active participation of the patient, and observes the content, and is far from a uniform treatment, is necessary.

4.5.4. Textbook Analyses and Real Life Practices

Expert clinicians have adopted certain attitudes presented by the books and lecturers they have read during their education. This is the product of a very rigid and systematic approach and is a mindset that clinicians adopt. Therefore, it will not be easy for clinicians who have been trained for years to make decisions and methods for the good of their patients to accept alternative thoughts and practices. Moreover, the third-person perspective has another important advantage over the second-person per-

spective: the concept is the objectivity and immutability of the physiological states of the body. From this point of view, a treatment is attractive by creating a reliable meaning world of certain results. This is the most important and fundamental advantage of psychiatry, which adopts the third perspective.

However, the intensity and severity of the third-person perspective can be observed by looking at the words used in the sources used in education and their frequency. For example, Kaplan and Sadock's Comprehensive Textbook of Psychiatry can be one of the most common and pioneering textbooks used in different continents of the world. It includes basic theoretical education, clinical practice, and treatment methods, and the importance it attaches to the body can be observed. The importance this book gives to patients can also be observed from the methods of healing the body. So much so that in the latest version, the 11th edition and volume I, the word pa- tient is mentioned 8,271 times and the word body 5,463 times in a total of 16,525 pages. The statistics of other words in which the third gaze is effective are as follows: 3727 times brain, 411 times objective, 457 times biology and 142 times biological,

3048 times medicine, 2975 times drug, 614 times neurotransmitter, and 5684 times symptom. The training they receive is so good for the body that it seems that psychiatric interviews and treatments do not fail even if they only read the sources, do not talk to the patient one-on-one, and do not know how the subjective aspect of the patient responds to the treatment and the disease. However, studies have shown that psychotic patients do not feel well even if they take their medication and follow their treatment exactly. According to this study, this is because the patient does not feel understood. In another study, it was observed that specialists did not respond to the questions asked by psychotic patients during the examination.

In the same study, it was reported that clinicians ignored the questions when patients repeated the question. In the article, the social interaction of the specialists during the examination was criticised, and it was stated that this point was not included in basic medical education. Medical doctors who adopt the principle of primum non nocere, i.e., first do no harm, cannot fully help their patients because they do not listen to them. In Kaplan and Sadock's Comprehensive Textbook of Psychiatry, the terms

related to sociability are as follows: 2037 times human and 71 times listening. These are the terms and attitudes necessary to understand and support the patient in the treatment process. This does not lead to a holistic and humane treatment but to the exclusion of the patient's own experiences. Patients suffer because their doctors do not involve them in the treatment process and do not understand their feelings and thoughts (Boland, & Verduin, 2024). Research has shown that psychotic patients drop out of treatment because they are not understood by their specialists (Dixon et al., 2016). In addition, the main textbook uses the terms acceptance 270 times, empathy 90 times, humanity 11 times, self-experience 9 times, family 2077 times, social support 101 times, and subjective experience 51 times. Again, the term holistic was used 23 times (the references given here include holistic approaches in drug treatment), dialogue 2682 times, specialist 420 times, and psychiatrist 6096 times. Similar situations are seen in Massachusetts General Hospital Comprehensive Clinical Psychiatry (2024). In 1006 pages, the patient is mentioned 858 times, social support 30 times, communication 69 times, and human 216 times. The term humanistic is used only 3 times in total, and psychoeducation is used 18 times. These rates and studies show that the experts do not listen to the patients and ignore them socially. Again, these results can be interpreted as that the experts are expected to diagnose the disease in their trainings instead of understanding the disease from the patient's point of view and that they are actually interested in the idea of the disease. This causes the specialist to focus on the disease and the symptom rather than the patient and to perform the treatment in an egocentric time and space. As a result, the third perspective heals not the patient but the symptom, the disease, and the body moulded by education. This process becomes very complicated when the expert's immersion in his own knowledge is combined with the psychotic's being lost in his own experience and unable to express it. Moreover, as long as the person takes medication or attends therapy, the treatment can be considered complete. However, treatment is a process, and this process is not only symptom- and body-orientated; the patient needs to be holistically well, and perhaps this is why even the textbooks used claim to use physiological, psychological, and social perspectives. However, it is clear that this is incomplete and that the psycho-social perspective of the patient is ignored in the terms used. This undermines the patient's trust in the treatment (the term trust was used 165 times in the textbook and 1523 times in the hospital).

In conclusion, the words, phrases, and intensities used in education are based on the third perspective. Although these are intended to cover patients' problems, they show that professionals do not listen to their patients and do not support them.

CHAPTER 5

ALTERNATIVE METHODS

Psychiatry has been influenced by paradigms and models shaped by multiple and different views throughout its emergence and development. As seen in the previous sections, different explanations have been developed for psychological states and psychiatric disorders. The most dominant of these, the biomedical model and alternative searches against biological psychiatry, have also emerged in the historical process. The main reason for these views and suggestions can be characterised as criticism of the explanation and treatment methods of the disease. Biological psychiatry has adopted an objective and third-person perspective that explains the causes of diseases on the basis of genetics and the brain. Phenomenological psychiatry, on the other hand, opposed the adoption of mechanistic and positivist concepts at the theoreti- cal level and proposed a philosophical background that would enable a detailed and in-depth understanding of the individual's experiences on the basis of a first-person perspective.

Therefore, phenomenological psychiatry started against biological psy- chiatry as a historical process. With the development of the biomedical model over time, it continued to oppose the theoretical views of this model. The biopsychosocial model is one of the most recent models and proposes a framework that can transform the clinical applications of the biomedical model. In short, phenomenological psychi- atry offers a theoretical critique, while the biopsychosocial model offers a practical adaptation. However, the effective methodology needed should be based on a structure that combines both the philosophical depth of phenomenological psychiatry and the practical success of the biopsychosocial model.

In this chapter, the shortcomings and criticisms of both concepts will be analysed, and it will become clear that there is a need not only for the understanding contained

in the theoretical propositions under a human, first-person perspective but also for a scientific and ethical model of psychiatry that fits the context.

5.1. Biopsychosocial Model

The biopsychosocial model was developed by George Engel against the dominant biomedical model and advocates a holistic perspective in the assessment of patients (1981). Engel criticised the limited nature of biological reductionism in his study and developed an alternative practice model. Accordingly, as seen in the name of the model, it is aimed at bringing together the biological, psychological, and social effects of people. According to him, the dominant model ignores the psychological and social notions of human beings, which creates incompleteness and incompatibility in the evaluation parts. Therefore, the proponents of this model do not see human health only as a part of a biological mechanism; on the contrary, they try to consider human health as a whole system that interacts with environmental and psychological factors.

However, the connection here is different from the relationship between the biomedical model and the third-person perspective of biological psychiatry, or the phenomenological psychiatry-first-person perspective, because the philosophical basis on which this model depends cannot be found directly. For example, according to Lewis, there is a connection between George Engel's biopsychosocial model and the pragmatism of William James and John Dewey (2007). According to this article, the model and pragmatism have some similar frameworks because these are the rejections of mind-body dualism, the emphasis on the importance of context for understanding phenomena, and the emphasis on practical results rather than abstract, philosophi- cal theories. In addition, the biopsychosocial model, which is based on pragmatist philosophy, focuses on some of the most important dynamics that affect a person's illness and health. These are biological, psychological, and social and are present in everyone. Since there is no need for deep theoretical and philosophical analyses, the health system considers it advantageous to follow the points that are most useful for it. Therefore, it can be said that the biopsychosocial model does not have a theoretical and deep philosophical background, because it does not need it.

The main arguments of this model can be explained under four headings. Firstly, the concepts of illness and health are multifaceted and multilayered. As the name suggests, these are biosociopsychological dimensions. The impact of each factor on a person's life and functioning has separate and multidimensional effects on their health and illness. For example, there may be neurotransmitter explanations of psychosis (biological), stress due to interpersonal communication problems (psychological), and stress due to the inability to maintain academic and work life due to poverty (social). These should therefore be analysed separately. The second argument is the dynamic nature of the illness. As seen on the basis of the first characteristic, the illness has more than one effect on the person. These are dynamic and fluid, both within themselves and in their interaction with each other. For example, the neurotransmitter explanations of psychosis can create problems and stress in interpersonal communication (biological), and the resulting stress can weaken the immune system of the defect (biological). The person with psychosis is therefore not expected to be outgoing or talkative (social) and may be more likely to be depressed (psychological). The third argument is that treatment should be multifaceted, acting on the first two characteristics. In other words, therapy is recommended in combination with psychopharmacological medication. In this way, increased psychological resilience provides social support, while medication provides neurological support and recovery. Finally, the patient is recommended to actively participate in the treatment process. The biomedical model is a model in which the patient is objectified and in a passive position. The patient in the receptive position will fulfil what is asked of him/her and take own medication. However, the biopsychosocial model opposes the passivised role of the patient. It sees the patient as an active individual who is reminded of his/her social and psychological role. Thus, the patient can monitor and understand his/her own health status and make appropriate adjustments to patients lifestyle.

5.1.1. Psychiatric Applications of the Biopsychosocial Model

It can be said that the biopsychosocial model is a broad health model, but with the integration of these components, it offers a valid approach in psychiatry for many years (Papadimitriou, 2017). According to Papadimitriou, it is a model that has gained popularity in different health fields, especially in psychiatry.

1. Holistic View: It adopts and promotes an interdisciplinary approach in psychi- atric studies and the clinical field. Thus, it tries to understand the effect of multi- ple variables on the patient in the most optimal way and provides a comprehensive perspective. In this way, etiological and nosological studies can be addressed in a more holistic and broad perspective. This may be advantageous for complex and still unresolved diseases such as psychosis, where there is no consensus on appropriate treatment.
2. Patient-centred approach: It adopts a model that emphasises the psychological structure of the patient instead of the expert-orientated approach of the dominant biomedical symptom model. Thus, in addition to biological treatments, psychother- apy and social support mechanisms come into play (Santos et. al., 2018).
3. Diversity in Clinical Practices: On the basis of the first two methods, the biopsy- chosocial model, which combines multiple approaches with a patient-orientated per- spective, tries to make psychiatric treatments in a broad perspective . Thus, it chal- lenges reductionist models and the dominance of the third-person perspective.
4. Egalitarian Structure: The holistic attitude of the model offers a diverse content contrary to the diagnoses, definitions, and classifications determined by the domi- nant paradigm. In this way, it can contribute positively to the integration of people subjected to economic, social, and cultural exclusion into treatment (Wittink et al., 2022). It can also contribute positively to treatment by creating alternative resources for individuals who cannot access the uniform mechanistic treatment of the dominant model.

As can be seen, the biopsychosocial approach offers a different approach. There are some psychiatric studies in the literature that have been successful by adopting this method. For example, according to Lazzari and Rabottini, Borderline Personal- ity Disorder (BPD) is very difficult to treat (2023). For this reason, comprehensive applications that integrate psychological, biological, and social concepts are recom- mended, and the biopsychosocial model is one of them. In this network-like model, a dynamic and holistic approach was used for BPD patients over time, and the treat- ment yielded positive results. Lazzari and Rabottini stated that they affected the neu-

roinflammation causing suicide by manipulating the stimulation of the cortico-limbic system and prefrontal cortex. In another study, group psychotherapy was applied to chronic patients such as those with cancer, AIDS, and coronary heart disease, and it was observed that positive contributions were made to the personal health processes and psychosocial needs of the patients (Dobkin and da Costa, 2000). All these examples show that this model evaluates the human being in a holistic and functional way, unlike other practices. Thus, the aim of providing comprehensive and effective care in complex health situations can be realised.

5.1.2. Criticism of the Biopsychosocial Model in the Philosophy of Psychiatry

In 1977, George Engel made invaluable and important contributions and challenged the existing uniform, mechanistic, and linear organisation. Moreover, the model he presented was open to development for different times and settings and offered a personalised structure. In this way, it was expressed and expected that he had a very important position in the field of psychiatry and philosophy because he showed that the basic arguments and emphases of psychiatry should change and that it was time for a paradigm shift in modern psychiatry. Nevertheless, a model that has made such important debuts is still not accepted as the dominant psychiatric model today and does not meet expectations (Deacon, 2013). There are also various philosophical and practical criticisms against the biopsychosocial model. The main ones are as follows.

5.2. Theoretical Issues:

The biopsychosocial model is trying to show its presence in current practice and clinical practice. The field of activity deals with bio-psycho-social paradigms by combining and reinterpreting them within itself. However, the model had theoretical problems on a philosophical basis. Moreover, from a philosophical point of view, it was most associated with pragmatism because—as mentioned above—it was shaped according to the immediate needs and functions of patients. However, it is not sufficient to solve these problems because it does not provide a methodological basis or framework from which perspective, why, in which content psycho-social and biological aspects will be addressed, which aspect will be prioritised, and how these interac-

tions can be measured objectively. As Pilgrim states, it does not provide a specific explanation of how different factors affect the psychiatric patient, nor does it have a consistent model for health and illness in general (2015). In other words, the biopsychosocial model, a dynamic model in which the most appropriate method for the patient is determined instantaneously, lacks systematic and theoretical foundations. For this reason, it also does not have a consistent and scientific diagnostic criterion, unlike the dominant biomedical symptom-based paradigm it opposes. Therefore, the biopsychosocial model only offers an approach for treatment, which is theoretically incomplete.

5.3. Epistemological Inadequacy and Pragmatic Reductionism:

Another consequence of not knowing to what extent, in what relationship, how, and in what content the factors used in the model affect the patient is the imbalance between these concepts. This knowledge, which is especially necessary for psychotics, is applied to the patient by trial and error, far from epistemological integrity. Moreover, there may be much more biological, psychological, and social than the observable symptoms recognised and identified by the DSM and the dominant paradigm. However, the biopsychosocial model, which opposes them, tends to apply them in an almost pragmatic reductionist way, instead of trying to investigate unidentified, unobservable factors. Therefore, the epistemological uncertainty and pragmatic reductionism of the appendices is another problem.

Epistemological Resource Incompatibility The biopsychosocial model aimed to bring together different types of information and resources to make inferences about health and illness and to provide personalised treatment. These sources consist of things like physical or neurobiological, subjective experiences, and social relationships. However, these sources of knowledge can be epistemologically independent, separate, and incompatible. In other words, sources of knowledge are subjective (first person), objective, and interpersonal, or second person perspective. This creates an epistemological source mismatch. These source discrepancies in turn create inadequacies and contradictions in theoretical and practical terms.

The Problem of Meaning of the Concept of Psycho and Social The social and psychological factors mentioned are predominant, but their meaning seems to be ambiguous and open-ended. Which social and psychological factors influence treatment? Are there psychological factors that do not influence treatment? Can these influences be identified? Although patients' culture, character, economic structure, family situation, and education are influential, how can their clinical impact be determined? What is the distinction between psychological and social? How can these factors be integrated or organised into clinical treatment? These issues show that the model has problems in defining, applying, and integrating psychological and social concepts. The solution is to treat them as a certain type of variable or fixed factor, which in practice leads to their neglect and distancing from the model. Moreover, due to their broad spectrum and nature, they can be difficult to express under specific definitions in scientific studies and to explain with operational definitions. This can lead to a reduction in scientificity, which will lead to the next item.

Unrealistic Goals The roadmap of the presented model aims to address the biological, psychological, and social aspects of psychiatric and physiological patients in a single and integrated manner. However, in the context of the third point, this may not be a realistic expectation and goal, as time and resource constraints of clinical centres and patients may prevent this. In addition, patients will not follow or consider psychosocial changes when they have positive results in biological treatments based on the biomedical symptom-based paradigm. Thus, although the model ideally sets an optimistic goal, it is at odds with real-life practice. On the other hand, the ambiguity of terms and definitions may also have an impact on this situation, causing people not to fulfil their expectations from the model. As a result, the model may be misunderstood or misused.

5.4. The Problem of Scientific Validity, Reliability, Objectivity

It can be said that the psychosocial factors and variables addressed by the previous items cannot be defined by operational definition, and the model is not objective enough. This shows that the concepts in the model are subjective. This weakens the claims that the structure is scientific and objective. This situation, together with the

above issue, may make it difficult to work in clinical research. Again, as stated in the third point, theoretical and methodological incompatibilities arise in the model where different disciplines come together. Since it is against the biomedical symptom-based approach, the medical practices and contents it follows are prioritised over psychological and social approaches in the hierarchy of knowledge. This situation weakens the egalitarian structure claimed by the model and makes the biopsychosocial model closer to the biomedical model than ever before. As a result, although it tries to address illness and health in an egalitarian and multidisciplinary structure, it harbours significant problems in philosophical theory and practice. Although the model tries to treat the human being as a holistic being, it may have problems in supporting this claim on an adequate theoretical basis and in practice. The criticism of the biopsychosocial model within the scope of the philosophy of psychiatry shows the need for a more holistic, scientific, and theoretical understanding. Therefore, the new model to be proposed should include both the subjectivity and experience accepted by phenomenological psychiatry, the scientificity of the biomedical symptom-based model, and the multidisciplinary structure of the biopsychosocial model. Before discussing what this model is, information will be given about phenomenological psychiatry as the second view developed against the biomedical symptom-based model.

5.5. Phenomenological Psychiatry

Phenomenological psychiatry, the second and last of the alternative models, is an approach based on philosophy, especially phenomenology, to understand and explain psychiatric disorders and takes a critical stance against biological psychiatry and its arguments popular in the 20th century (Larsen et al., 2022). According to them, this approach is based on a first-person perspective as it focuses on subjective and personal experiences, in contrast to the scientific and third-person perspective of biological psychiatry and its advanced model, the biomedical neighbourhood-based approach. In this respect, it does not make a health-disease distinction like the biopsychosocial model or psychopathologise individuals like the dominant model; it deals with the problems in individuals' lives in an existential way and focuses on their relationships with the world (Irarrázaval,2020). Therefore, the positivist and mechanistic nature of the biomedical model can be understood to be in contrast with psychoanalysis' focus

on unconscious processes and its attempt to scientise them like other famous methods of its time. As a result, phenomenological psychiatric psychoanalysis operates in a completely separate way from biological psychiatry and the biopsychosocial model; it does not define people, behaviours, and situations in terms of bipolar extremes such as abnormal-normal, pathological-healthy. It tries to construct people's experiences, thoughts, and feelings through their worlds of meaning.

5.5.1. The Birth of Phenomenological Psychiatry

Johann Christian August Heinroth was an important figure in the early period of psychiatry. In his time, in 18th-century Germany, the emerging biological elements of psychiatry were emphasised. For some thinkers, this emphasis meant that the field accepted a more materialistic line . However, the same orientation led to the emergence of opposing ideas, arguing that analysing the structure and function of the brain would not be sufficient to understand mental illness and that the individual's environment and interactions within that environment would not be sufficient to understand mental illness. For instance according to Cauwenbergh, Heinroth was one of the proponents of this view. Heinroth, unlike others, believed that the mental health of the person would be possible through their personal understanding and interpretation of the world and that the person's experiences should be at the centre (1991). Thus, he emphasised subjectivity and one's relationship with the world, and in a sense he was one of the pioneers of phenomenal psychiatry.

Again, for Cauwenbergh, Heinroth, like his contemporaries, did not consider a moral approach necessary for mental health and tried to analyse mental problems within the body-mind-spirit triad and was even considered the first psychotherapist in psychiatry. However, Heinroth's method draws a picture far from the discipline of the phenomenological method because he tries to understand the relationship of the individual with the body and the world through his subjective existence. Thus, his position may bring him closer to an existentialist line rather than a phenomenological line. As a result, Heinroth's work pioneered the emergence of phenomenological psychiatry and contributed to looking at human beings through their existence, subjectivity, and experiences.

5.5.2. Development of Phenomenological Psychiatry

Phenomenological psychiatry, which criticised mechanistic and reductionist approaches to understanding and treating human nature and psychiatric illness, was not, like previous attitudes and models, a largely clinical practice. Rather, it offered an interdisciplinary approach that also worked with philosophy and psychology to understand man and his nature. Consequently, these interactions sought to explain their philosophical origins and relationships within a specific discipline and methodology, rather than evaluating psychological and sociological factors in a pragmatic and functional way, as the biopsychosocial model did. Therefore, it may be more useful to evaluate the development of this view from a philosophical and psychiatric perspective.

5.5.3. Philosophical Perspective

Phenomenological psychiatry began to be heavily influenced by Continental philosophers and to adopt their methods in the early 20th century. Because they had similar questions and quests with phenomenology and existentialist movements that placed human beings in an active position in the search for meaning (Zahavi & Loidolt, 2022). It is useful to discuss the reasons for the cooperation of philosophy and psychiatry, which seem to be instinctively opposing disciplines, in order to understand the role of philosophy and the philosophical perspective.

One of the first reasons for the intersection of psychiatry and philosophy is that practitioners aim to find answers in human experience. Although the reductionist and mechanistic attitude of biological psychiatry, which gained strength in the 20th century, distanced psychiatry from the philosophical perspective, some psychiatrists opposed this and wanted to refer to specific and subjective experiences to understand the relationship between man and the world for Zahavi and Loidolt. Also, Phenomenology, one of the philosophical currents of the period, also advocated a method that analysed the essence of human experience and thus the structures of experience and Edmund Husserl, one of the famous phenomenologists of the 20th century, developed the phenomenological method to understand what human experience was (Gurwitsch, 1966). So, in this method, what the essence is could be understood, and how human

beings understand, perceive, and make sense of the world could be revealed. This problem and the method put forward were similar to the fundamental search of psychiatry, which was tired of the reductionist attitude of the period, and it could be said that it was a great escape for this group, which wanted to analyse the world through experiences in order to understand people's mental problems. Moreover, psychiatrists had a ground on which they could analyse subjective meanings as they wished. Indeed, phenomenological psychiatrists did not adopt Husserl's method and the name of the tradition to which he belonged and tried to establish mental disorders through the concept of directionality (Wiggins et al., 1992).

Other one of the important people who established this relationship is Karl Jaspers in this field and he aimed to apply the phenomenological method in psychiatry and accepted it as a practical tool in understanding people's mental problems (Jerotić, & Pantović, 2021). For the emphasis on instrumentality or tool may be important because, according to the source, Jaspers and phenomenological psychiatry did not fully embrace philosophy. In fact, according to them, this method was too idealised and ignored the concrete experiences of people.

Therefore, according to Walker, Jaspers accepted Husserl and his method as a tool and argued that phenomenology should be different from a philosophical ideology and should have empathic and concrete components. This attitude shows that Jaspers and other experts could not completely break away from their scientific identity and that a flexible and embodied phenomeno- logical understanding is necessary to regulate the chaotic essence and experiences of human beings.

The first reason for the cooperation of psychiatry and philosophy, the search for the meaning of mental problems in human experience, has similar aims and methods. However, the divergence begins at the point where Jaspers and psychiatry try to adapt phenomenology to the clinical context. This divergence, although it involves opposing orientations and claims, is one of the most fruitful connections for psychiatry and philosophy. Thanks to the rich intellectual connection that emerges, one can understand how psychotic people perceive the world and themselves and what is distorted in the process of this perception.

The second reason for cooperation is that they oppose the dominant point of view of the time or a third-party perspective. Philosophy, by its very nature, discusses different schools of thought and ideologies. In this context, it adopts some views and rejects others. Biological psychiatry explains all psychiatric disorders, and the biomedical symptom-based model explains most of them in terms of brain and bodily processes. Although the former recognises genetics and the brain and the latter recognises specific brain abnormalities and neurotransmitter imbalances as causes, the underlying origins are the same: third-person perspective. In contrast, the phenomenological tradition and existentialism argue that the effects of biological factors and processes cannot be fully explained in understanding the human psychological state for Kendler and Ellenberger. According to them phenomenological psychiatry argues that such mechanistic views and claims ignore human subjectivity and existential meaning. For example, although panic disorders can be explained in terms of the nervous system or neurotransmitters, this alone is not sufficient, as it may also be related to the loss of hope for the future. Or two of the psychotic symptoms, hallucinations and delusions, may be the result of biological causes, or they may be a sign that the psychotic person's perception of reality and the way they make sense of the world have changed. All these claims and objections have created a critical perspective in the field of psychiatry and the philosophy of psychiatry, questioned the biomedical paradigm, and brought to the agenda the subjective experiences that the biopsychosocial model fails to address.

As can be seen, the second reason for the cooperation between psychiatry and philosophy, the opposition to the dominant third-person perspective, provides diversity and contribution to the practices in the field of psychiatry. This will pave the way for the third reason. The third reason for cooperation is the desire to contribute to the existential search for meaning by practitioners of both fields. Existential philosophy focuses on the search for meaning through various issues such as fear of death, freedom, or existential concerns. However, some of the psychiatric disorders occur as a result of problems in making sense of oneself and the world. Although the biomedical model reduces these to biological causes, the behavioural consequences are different; in particular, some illnesses make existential questioning behaviourally observable. This concept is particularly easy to see in depression and anxiety. Phenomenologi-

cal psychiatry creates an existential plane for patients at this point and contributes to the search for meaning through its analyses. These contributions can be seen in the works of experts such as Ludwig Binswanger, another important name in the field (Basso, 2012). Binswanger is one of the most important phenomenological psychiatrists of the 20th century and brought the Heideggerian approach to psychopathology and psychotherapy. As a result, he developed Daseinsanalysis (Frie, 1999).

Martin Heidegger is first of all the second phenomenologist to come to the fore in the philosophy of psychiatry. His influence on the philosophy of psychiatry is closely related to the concept of Dasein. He is one of the people who did this; it was Ludwig Binswanger, and inspired by the existentialist movement, he put forward the concept of Dasein for Frie. According to this, a human is not only a biological being but also a being who seeks meaning, experiences his existence in the world through himself, and establishes a relationship with others (Ellenberger, 1958). Moreover, Binswanger focused on Heidegger from these perspectives in psychiatry, but he did not explain mental states and problems only for biological reasons; instead, he evaluated them through time, space, and relationships. Even there can be examples given in this context: According to Holzhey-Kunz, schizophrenia is the loss of one's ontological meaning in the world, because the patient now experiences foreignness and fragmentation in the world. Depression, on the other hand, can be explained as the closure of one's perception of time towards the future (1996). Therefore, psychotic processes can also be considered as a loss of self. Furthermore, the transition from the abstract to the concrete has accelerated with the cooperation of psychiatry and philosophy in the search for existential meaning. In other words, for the solution and treatments of the psychiatric problem and recovery, the patient can create new meanings through different experiences, reinterpret past experiences, and direct future expectations. In this way, a therapeutic bond between the patient and the expert can be established in accordance with psychiatry. However, the treatment process can be observed indirectly, because these bonds and approaches will be effective as long as patients continue their experiences in accordance with their authentic selves and the meanings they create.

Finally, Eugene Minkowski was the third important psychiatrist of the 20th century. Unlike Ludwig Binswanger, he worked specifically on depression based on Edmund

Husserl and Henri Bergson (Pachoud, 2001). According to Pachoud, Minkowski closely linked psychiatric disorders with distortions in one's perception of time and space, because in order to understand one's own existence, one needs to look at the content of one's experiences in a particular time and space. Psychiatric disorders such as depression are analysed in terms of the concept of élan vital, which is defined as a person's life energy or sense of vitality. Depression, on the other hand, is the impairment of this energy and emotion and the deterioration of the human ability to establish meaningful relationships in the world (2016). Again, Pachoud notes that Husserl's influence can be observed in his attempt to explain psychiatric illness through temporal and spatial contexts of existence. As a result, unlike previous psychiatrists, Eugene Minkowski developed a distinctive, authentic, and especially phenomenological meaning of psychiatry. This has shown that psychiatry can be reinterpreted with existential and phenomenological content and can be reinterpreted on a phenomenological basis in clinical cases.

In conclusion, the reasons for the intersection of the two fields, which at first glance seem to be instinctively opposed disciplines, can be summarised as the practitioners' search for answers in the same place, namely in experience, their opposition to the third-person perspective, and their desire to contribute to human existence. All this was made possible by psychiatrists such as Karl Jaspers, Eugene Minkowski, Ludwig Binswanger, and Medard Boss, who followed Edmund Husserl, Martin Heidegger, and Henri Bergson. In other words, philosophy shaped psychiatry and created a new paradigm and view. This view is called phenomenological psychiatry.

5.5.4. Effects of Phenomenological Psychiatry in Clinical Field

This new and emancipatory environment provided by philosophy to psychiatry made significant contributions to theoretical studies because, for the first time, psychiatric disorders were not seen only as observable neighbourhoods as defined and limited by the dominant paradigm. Patients could be re-evaluated with different terminol- ogy, disciplines, and perspectives. Thus, patients were no longer seen as a biological problem and existed only on the basis of their symptoms, which they possessed to the extent and in the meanings they were allowed to have. Rather, it was realised that the

person is an experiencing subject. This was the first point at which the biomedical model and the biopsychosocial model diverged. Psychiatric disorders were caused by the subject experiencing problems such as fragmentation in an attempt to make sense of the world. For this reason, illnesses were not explained by biological causes and once again differed from the other two models.

Phenomenological psychiatrists, as seen above, saw depression as a problem in the perception of future meaning and temporal perception, anxiety as the experience that one's existence was under threat, and schizophrenia as the temporal and spatial fragmentation of the experience of the self and detachment from the experience of the world. Therefore, a holistic method focusing on subjective experience is proposed, and the proposed holism can be explained by the reestablishment of meanings and the reconstruction of the self in a particular place and time in the social world in which the person lives. Therefore, the proposed therapy can be considered as a method that follows meaning and experience on the basis of primary perspective and where intersubjective dialogue comes to the fore. In this way, the therapist not only monitors and suppresses the symptoms but also guides the individual to reconstruct his/her world. Therefore, interpersonal dialogue is more prominent than the dominant model, and a meaningful relationship between the therapist and the patient is tried to be created for Ellenberger. This is more human and warm than the dominant paradigm is accustomed to; the therapeutic relationship is reciprocal. The therapist mutually nurtures the patient, and the patient mutually nurtures the therapist and helps both sources to make sense of their lives. Thus, the human aspect is emphasised in clinical prac- tice, and empathic awareness is tried to be increased. It can also positively influence the development of contemporary psychiatric practices. For example, Values-Based Practice (VBP) will be emphasise the first-person perspective of the patient and clinician in clinical decisions and highlights the human and empathic aspect. This can be considered as a concept compatible with a phenomenological psychiatric view. Moreover, and more importantly, it has been frequently emphasised in the philosophy of psychiatry in recent years that diagnostic systems lack subjective values and experiences and first-person perspectives. Therefore, by discussing the possible adaptation of phenomenal elements and understandings to modern psychiatric practice, appropriate diagnostic-treatment methods can be developed.

5.5.5. Criticism of Phenomenological Psychiatry

Although phenomenological psychiatry offers philosophically based alternative approaches to the third-person perspective and its basic models in psychiatry, it is criticised for not providing sufficient methodological grounds and consistent applications. On the other hand, it is considered scientifically inadequate because it excludes scientifically recognised validity and reliability processes.

The methods applied in psychiatry are based on first-person perspective, subjective and phenomenological. Accordingly, reports containing subjective evaluations are also biased. In order for psychiatric treatment to be carried out correctly, diseases must be fully understood, and the mental processes of patients must be systematically comprehended. However, patients cannot fully trust even their own mental processes and express that they ‘’say more than they can know” (Roser & Gazzaniga, 2004, as cited in Bentall, 2015). According to the same source, even if phenomenologists say that the method they use does not create a problem, the fact that psychotics have problems in accessing their introspection will be one of the consequences of their illness. Therefore, a phenomenological approach and questioning can be more complex and challenging than introspection. Because while introspection is direct and immediate access to the person himself/herself, phenomenological inquiry methods access the patient’s core experiences, possible assumptions, possible interpretations, and meanings through the patient. This becomes much more challenging in complex emotional states, speech difficulties, and blurred mental processes such as psychosis, depression, or anxiety. In catatonic states, schizophrenics cannot even react. This prevents what the patient knows about himself or herself from being meaningful, valid, reliable, and treatable. Therefore, objective criteria for the validation of phenomenological concepts cannot be found, claims cannot become findings, and generalisation is difficult. While phenomenological psychiatry is based on subjectivity and experiences, it uses the resources that the biomedical septome-based model it criticises uses in the diagnostic process. These resources are observable and measurable symptoms and behaviours. Although the dominant model of phenomenological psychiatry criticises categorised diagnostic resources such as DSM and ICD, it accepts and uses the terms used in these resources in clinical practice to use a common language and facil-

itate the treatment process (Abettan, 2015). However, this is a contradiction because this tradition adopts the first-person perspective in almost all areas while using the third-person perspective, which they criticise, for diagnosis and treatment. Therefore, the unique and authentic experiences of patients can be ignored, and their treatment can be standardised.

Another point where phenomenological psychiatry is contradictory is that the reductionism it criticises focuses on subjective experiences and neglects biological, social, and environmental effects. Another criticism that can be made is its attitude that underestimates the interactional structures formed by social and social structures in order to maintain the individualistic perspective it emphasises in psychiatric disorders. Such an attitude may lead to the ignoring, incompleteness, or misunderstanding of the context and social factors in the evaluation of the patient and the illness. Another problem is that it is difficult to conduct studies because they are far from scientific and systematic structure. Patient interviews can be also time- and energy-consuming as they are open-ended and thematic. Since the therapist will add his/her own interpretation process, this may create problems for other experts to follow and understand. Thus, the teaching process is hindered and serves a limited group. As can be seen from research and studies, depression and schizophrenia are also emphasised. Since this creates knowledge and experience in working with specific types of illness, conditions, and people, other psychiatric disorders in real life will inevitably be excluded. On the other hand, in comorbid situations where more than one disorder is diagnosed, interpretations and assessments can cause problems. In both comorbid conditions and single disorders, patients' experiences may be misinterpreted or over-interpreted by clinicians. This may lead to consequences that negatively affect the diagnosis and treatment process.

CHAPTER 6

PERSPECTIVES

Perspectives provide important clues for understanding an issue. They also provide important insights into how this can happen and why methods and practices are accepted or rejected. Psychiatry is a medical field that uses different sources of knowledge, theories, and explanations for mental disorders by understanding human mental processes and emotional states. These explanations can be not only scientific and objective but also psychological and philosophical, from each discipline's own point of view. The use of such different epistemic resources is particularly necessary to try to understand the nature of different conditions and concepts, because psychiatry is not only neurobiological or phenomenological in nature. On the contrary, psychiatry has scientific and philosophical aspects. Therefore, there is a role for scientific knowledge, just as there is a need to focus on subjective experiences in order to understand a person's condition at a particular time and place.

All these claims and studies try to find a place in psychiatry based on fundamentally different perspectives and constitute the philosophy of psychiatry. The philosophy of psychiatry forms the basis for its own clinical practice and application, using different or opposing theories to understand the nature of psychiatric disorders, using its own onto-epistemological concepts and ethical questions to understand the nature, aetiology, and nosology of psychiatric diseases, disorders, diagnoses, and treatments. All these rich dialogues can be said to form between the central points of the two perspectives. These are the first-person (1st person) perspective, based on phenomenological psychiatry, where subjective and experiential aspects predominate, and the third-person (3rd person) perspective, where a biomedical symptom-based model emerges from the premise of a scientific, objective, systematic structure.

At the end of the chapter, the way to realise the model and paradigm change that has been needed in psychiatry for many years will be proposed to change under a new perspective, taking into account the positive aspects of the perspectives on which the existing models in the field are based and originated. The new and alternative perspective to be proposed is the first step of a holistic, interdisciplinary, ethical, personalised model in which experiences are included in the second-person perspective (2nd person), the harsh and insurmountable nature of subjectivity is softened with technological tools, bodily cognition is active, social resources are actively used, and the useful nature of scientificity is not abandoned. For these purposes, it also aims to create a basis for the discussion of possible field applications in personalised medicine and precise psychiatry, which are expected to become widespread in the future. At the end of this goal, by trying to end the previous ruptures, such as subject-object, internal-external, spirit-body, philosophy-science, and logical positivism-phenomenological method, it can be used in the diagnosis and treatment of people in whom subjective experiences such as psychosis and processes such as embodied cognition are factually different. It also aims to reduce the tension between the insurmountability of the subjectivity of the first-person perspective and the non-intrusiveness of the objectivity of the third-person perspective and to establish a dialogue. Thus, this perspective can scientifically understand the authentic experiences of patients, provide a personalised approach by reconstructing the personalised therapeutic relationship and the social environment in accordance with the patient, and provide scientific diagnosis and treatment.

6.1. The First Person Perspective in Philosophical Psychiatry

According to Michael Paunen (2012), first-person perspective is the perspective from which one utilises one's own private and subjective experiential, perceptual, and emotional resources. From this perspective, it can also be perceived, or is perceived, in relation to one's knowledge of oneself. For this reason, the perspective of the known person is also related to the inaccessibility of other people and resources to the subject's inner process. It therefore asserts the privileged position of the subject as the sole experiencer. According to Pauen a person sees himself as a source of knowledge and that this situation is only open to him is related to the level of knowledge he can

access. For example, in behavioural terms, the verbal expressions of someone who says that they have a headache indicate that they are in physical discomfort. However, no one can experience the pains, aches, and feelings of this person. In contrast, in the first-person perspective, one can access information about oneself in two ways. One can experience oneself through immediate and direct self-awareness, or one can remember past experiences (Zahavi,, & Parnas, 1998). Furthermore, the epistemic access barrier has a close relationship with the unbreakable and insurmountable nature of subjectivity. Accordingly, the person experiences psychiatric illness and its processes only by themself and that is closed to all other agents.

The active use of the first-person perspective in the philosophy of psychiatry has, as already mentioned, been based on phenomenal methods and phenomenological psychiatry. Within the scope of the phenomenological method, psychiatric illnesses have achieved certain definitions and diagnoses, and their domains have been identified as self-disorders (Borda & Sass, 2015). However, due to the existence of epistemic access, these disorders are closed to the outside world. Therefore, the first-person approach attempts to provide the patient with intellectually rich insights through the expert, and personalised descriptions aim to retell the illnesses to the patients.

6.2. The Third Person Perspective and Affects of Philosophical Psychiatry

The third-person perspective is the predominant perspective in medicine, involving the evaluation of external and observable sources, using data that can be measured and observed. The methods, sources, and contents are used in scientific research because science is inherently measurement-based, experimental, and observational. Unlike the first-person perspective, there is no privileged access. On the contrary, anyone who meets certain criteria will have a third-person perspective. For example, a steaming cup of coffee drunk in cold weather offers the same data and results to everyone who meets certain criteria (such as being cold, having coffee, and having a sense of taste and smell). Therefore, the effects of cold air and hot coffee on the skin, the smell, and the taste of coffee are information accessible to everyone with a certain level of sensory perception and cognitive content. Thus, information sources

and access methods are almost the same for everyone and provide almost the same results.

As explained earlier in this thesis, psychiatry has adopted this perspective in its endeavour to establish and advance scientific certainty. Therefore, the biomedical-symptom-based approach has also adopted a focus on observable behaviour and symptoms, standardised diagnostic criteria and classification systems, and has prioritised objectivity. Because it establishes the relationship between the third person and the biomedical model through Copernicus and Newton's mechanistic understanding of the cosmos. Again, for example, according to Weinert, Copernicus and Newton's mechanistic understanding of the cosmos claims that all phenomena in the universe can be explained by certain laws and therefore can be objectively evaluated and predicted. According to Kauffman and Gare, Descartes also acted with this understanding and thought that the processes between the body and the brain could be explained on this basis (2015). Therefore, the organic link between reductionist approaches and objective evaluations between science and medicine can be established on this basis. The current biomedical-symptom paradigm, which supports this assumption, makes explanations that emphasise the neurochemical and biological factors of psychosis and recommends psychopharmacological drugs.

Consequently, the tense relationship between the 1st person and the 3rd person will not only be observed in psychiatry. On the contrary, this tension also has histori- cal and philosophical backgrounds. More importantly, modern psychiatry's search for a single perspective, or the belief that only one can be right, must come to an end. Moreover, each perspective is incomplete in itself, and its contradictions be- come more apparent in the face of each other. The models and the practices based on them will also be inadequate for these reasons. Nevertheless, it would be wrong to completely abandon perspectives with valuable knowledge and practices; it is necessary to include the positive and rich aspects of the perspectives in the process. The second-person view that does this is suitable for philosophical origins and scientific studies that can be developed on the basis of new methods, models, and paradigms in the philosophy of psychiatry.

6.3. The Second Person (2rd person) Perspective and Affects of Philosophical Psychiatry

First of all, the second person (2nd) perspective cannot be limited to 1st and 3rd person sources as sources; it also focuses on intersubjective relational aspects, social interactions, and contexts in order to understand the mental processes of the individual. It aims to act without limiting itself to only objective or only subjective structures and emphasises the concept of intersubjectivity by illuminating people's worlds of meaning through mutual relationships (Fuchs, 2010). The second-person perspective is a perspective that is recommended to be used in the diagnosis and treatment of psychiatric disorders due to its nature and technical aspects (Fuchs & Dalpane 2022). Intersubjectivity and second person perspective is also proposed by Schilbach, especially in empirical cases where subjective experiences such as psychosis are involved in the process and scientific justifications for differentiation (2016). Because as a result of their research, they have revealed that mutual communication and interaction are necessary to overcome problems such as communication problems and blurring of meaning experienced by psychotics. Therefore, the understanding and empathic communication that begins with the clinician enables the patient to realise that they will be accepted over time. The psychotic thus realises that his/her experiences are understood and his/her self is accepted. The second-person perspective plays the role of a therapeutic bridge. Once the patient feels safe and accepted, the rate of treatment compliance and continuation will increase in clinical practice. Again, according to Schilbach studies, it has been shown that some psychotic disorders are compatible with the second-person perspective in neuropsychiatric applications, and it has been claimed that studies in this direction will increase in the future.

Therefore, the second-person perspective aims to gain the trust of psychosis, to end the state of being embedded in the core of the self, to make scientific and ethical treatment possible, and follows some practices in this context. The first of these enables the conceptualisation of actions and shared experiences in order to understand psychotic or other patients. For example, schizophrenics have problems understanding the thoughts and intentions of others. By adopting a second-person perspective, the

therapist first recognises the patient as the subject. This is the first situation in which the person is removed from the dominant system that passivises their role. During the therapy process, not only observable behaviours, symptoms, and signs are followed, but also the psychotic's statements, words, and behaviours are listened to, and his/her world of meaning is tried to be understood by the therapist. This understanding is different from the third person; it does not label the patient's delusions as 'false beliefs.' On the contrary, it is followed how the psychotic makes sense of what and for whom. It is also different from the first person, because the dialogue between expert and patient allows them to become aware of their emotional state and to construct it. This can also include behaviourally instructive interventions. This is a deviation from the phenomenological method.

The second feature of the second-person view is that the intersubjective concept is related to early developmental processes, and the results are compatible with scientific observation (Galbusera & Fellin, 2014). In this study, it is stated that there is no need for the Theory of Mind concept developed to understand social cognition; instead, infants can understand others by following their early emotional and physical intersubjective interactions. Moreover, it is claimed that infants with good intersubjective interactions will be in good harmony with their carers, and this will form a basis for mental and communicative development (Kaye, 1982; Trevarthen & Aitken, 2001, as cited in Galbusera & Fellin, 2014). In other words, second-person perspective manifests itself in line with neuro-psycho-developmental processes and transforms into the capacity to understand others in later processes. Another point emphasised in the study is that the second-person perspective is a very natural element of the natural developmental process of human beings. People are not only born with the notion of second person, but thanks to this notion, they also realise that they are active subjects in the world by acting on the basis of daily life practices and subject content, not like scientists. This may cause problems, especially in psychotic patients. Similar to the learning process in the parent-infant relationship, this perspective can be mod- elled and realised in the therapy room between expert and patient. In this way, the complex group dynamics of different relationship networks can make sense of psychosis. In contrast to the shallow and narrow nature of the third-person perspective, the second-person perspective can be used to understand intersubjective experiences

in a variety of cultural and social contexts. Due to its contextualised nature, it can be applied to different people, situations, times, and places. As these efforts of the patient and the specialist proceed through subjective experiences, they also involve a phenomenological approach. When the patient is present as an active participant in the treatment, patient is not a passive source of information; he/she is a subject who wants to understand their own subjectivity and relationships with others.

Similar to the learning process in the parent-infant relationship, this perspective can be modelled and realised in the therapy room between expert and patient. In this way, the complex group dynamics of different networks of relationships can make sense of psychosis. In contrast to the shallow and narrow nature of the third-person perspective, the second-person perspective can be used to understand intersubjective experiences in a variety of cultural and social contexts. Due to its contextualised nature, it can be applied to different people, situations, times, and places. It also includes the phenomenological approach as these efforts of the patient and the specialist proceed through subjective experiences. As the patient is an active participant in the treatment, the patient is not a passive source of information; he/she is a subject who wants to understand their own subjectivity and their personal relationships with others.

These are the characteristics of a second-person perspective that is appropriate to the natural and developmental processes of psychiatric patients, especially psychotics, is open to scientific adaptation, and incorporates phenomenological and humanistic elements. These recommendations will not only help to increase patients' trust and compliance but also strengthen the likelihood that the necessary scientific treatment will be successful. In the next section, the bases and reasons why treatment approaches and interventions based on the second-person perspective are particularly appropriate for psychotic patients will be discussed.

CHAPTER 7

APPLICABILITY OF THE SECOND PERSPECTIVE TO PSYCHOSIS

In this last section, some treatment modalities based on the second-person perspective will be proposed. Although these are aimed at psychotic patients, they can also be used in comorbid and different types of psychiatric disorders. Moreover, due to the interdisciplinary and contextualised nature of the perspective, it is also possible to develop it. Treatment recommendations are presented within the scope of the three main points listed by Michael Paunen for the second-person perspective. In the first chapter, these three points will be briefly explained, followed by the newly developed treatment suggestions. At the end of the chapter, it is aimed to understand that the nature and structure of the second-person perspective, which is the main argument of the thesis, is compatible with the psycho-socio-phenomenal and cultural structure and can be worked in cooperation with scientific treatments in psychiatry.

7.1. The Theoretical Principles of Treatment Based on the Second-Person Perspective: Michael Paunen's Three Principles

Psychiatry can be expressed as the realisation of practices based on different theories. The two main application methods in history have based their theoretical work on the concepts of the first person and the third person and have determined their strengths and weaknesses accordingly. Only the theoretical background of the biopsychosocial model, which is one of the current implementation models, could not be directly associated with both ideas; instead, it was associated with pragmatism (2007). This study not only proposes the second-person perspective as the dominant perspective in the philosophy of psychiatry, but in order to keep the theoretical background and philosophical roots strong, it builds the treatment methods recommended for psychotic patients on the five requirements that Paunen grounds in the second-person perspec-

tive. In this way, a start can be made to overcome the lack of theoretical infrastructure that the biopsychosocial model and its analogues have.

Michael Paunen argues that replication, self-other distinction, and situational distinction are the basic principles of the second-person perspective. Based on these, the second-person perspective can be distinguished from other perspectives, the dynamic structures, contents, intersubjective meanings, and contexts of interactions with other subjects can be understood, and a basis for therapeutic, scientific, and ethical practice can be established (2012). These three principles can be used as a guide, especially in the treatment of psychotics, but also in the discussion of alternative resources that can be used in the future for different types of patients and within hierarchical diagnostic resources by discussing diagnostic implications.

7.1.1. Replication

In the first requirement, one's own subjective resources are used to understand the mental states of others. These are experiences and imagination. According to Pauen, the resources used for replication distinguish it from the third-person perspective because the reductionist method explains mental states in terms of objective data and theorising. In the second person perspective, the person uses past experiences. If the patient has no experience in this sense, the person imagines what such a situation would be like, how the person would feel, and uses their imagination. Therefore, he emphasised intersubjective empathy and sharing of experiences. According to Paunen, copying, which is the first condition of second-person perspective, has both philosophical roots and empirical evidence. One uses one's subjective experiences to understand the mental states of others or to attribute mental states to oneself, which is based on phenomenology (2012).

Similarly, Adolphs et al. (2005), as cited in Pauen (2012), argue that imagining is similar to simulating a particular mental content or mental/behavioural state.There are other brain imaging studies that support Paunen's arguments because mirror neurons can also be associated with the phenomenological method. This can be explained by the fact that humans are prone to the phenomenological method or existential search,

as well as having biological structures neurologically suitable for intersubjective interaction and socialisation. Hence these results can be explained by the theory of mind and reveal the pragmatic and intuitive aspects of communication and agreement. Consequently, through replication, it is possible to have things that most closely resemble the mental and emotional processes of another subject.

7.1.2. Self-Other Distinction

In the previous sections, it was observed that the thought and emotional processes that the other has can also be present in the subject. However, the subject also needs to realise that the situations he or she imagines or remembers from previous experiences belong to someone; that goes far beyond imitation. The key point here is the realisation that another person's mental contents and emotional processes belong to him/her, and this will clearly initiate the distinction between cognition, the self, and the other. The subject's perception that there are other subjects is the basis of the intersubjective situation.

7.1.3. Situational Distinction

Michael Paunen has shown that one can experience or imitate the mental/emotional process of another using one's own resources. He also pointed out that one should clearly realise that the mental/emotional processes one wants to understand do not belong to oneself but to another subject. For this, the individual needs to realise his/her own situation and clearly understand the differences in the situation of others. According to Paunen, this situation has developmental notions because when young children close their eyes, they create the perception that those around them cannot see them. In other words, when the baby closes its eyes and cannot see its surroundings, it cannot distinguish the people around it and thinks that it will be invisible. Therefore, the last condition for second-person perspective is that the subject clearly realises and understands that his/her situation will be different from other subjects.

7.1.4. Suitability of the Second Person Perspective for Psychosis

The three concepts mentioned previously are necessary for a second-person perspective. However, the use of this perspective, especially for the understanding and treat-

ment of psychosis, can make a significant difference. Because of the nature and experience of the illness, the second-person perspective is problematic in this disorder. Even if scientifically recognised factors cause or influence psychiatric illness, the illness does not exist only in a pathological sense; there is another aspect and meaning in which the illness affects the patient. This part is not opposed to scientific methods, attitudes, or facts; on the contrary, the second point of view does not look at the nature of the illness but at its effect on patients and their way of life. It differs from the first-person perspective and methods in that it accepts scientific methods and influences and advocates their application. It differs from the third-person perspective and practices in that it recognises experience, social support, intersubjective interaction, attention to context, and the existence and effects of psycho-socio-cultural structures. So, the second perspective advocated in this study advocates scientific and ethical diagnosis and treatment by attempting to identify the effects of psycho-socio-phenomenal concepts in a patient-specific manner. Thus, conditions such as psychosis, where psycho-socio-phenomenal constructs dissolve under the scientificity of the illness, are well suited for the second perspective. Moreover, psychotics experience the specific complex nature of the illness in the context of Michael Pauen's second-person perspective conditions. The specific difficult situation of psychosis can also be observed in the problematic experience of the concepts of replication, the distinction between self and other, and the social distinction. Especially in the content of episodes such as paranoid delusions, patients attribute their own subjective thoughts/feelings to others, think or imagine them, and simulate them.

Again, the psychotic paranoid reflects his/her paranoid emotional contents to other people by not seeing them as their own. Or patients are not aware of the differences in other people's opinions, evaluations, and perspectives during active episodes. Similarly, they may not realise that hallucinations or delusions frighten other people, or they have difficulty in expressing that they themselves do not pose a threat. These are examples of problems with concepts based on Pauen's second-person perspective.

If all three principles of psychotic patients are problematic, the second-person perspective will affect their functioning, their experience of self and body, and their relationships and communication with other people. Consequently, this perspective is

therefore perhaps more prominent in psychotics than the first- and third-person perspectives. This may be the reason why the dominant paradigm and other practices offered as alternatives are insufficient to understand problematic situations. Thus, psychiatric patients, especially psychotic patients, are deprived of the most appropriate diagnosis and treatment. In the following, some treatment suggestions are given to avoid these problems.

7.2. Treatment Recommendations

In the light of the above, the prevailing modern, third-person perspective paradigm has made numerous contributions to psychiatry, aiming to apply the most reliable and appropriate treatment methods to everyone in different circumstances. No matter how fluidly the philosophical underpinnings of the theoretical methods of application are interpreted, this is a grounded part of science and medicine. At this point, the second-person perspective recognises the body of science and its contributions on this solid ground. The second-person perspective criticises the more effective and efficient use of scientific contributions, the lack of a general idea, ideal, or stereotype of the body, and the nonverbal, cold, and hierarchical approach to treatment.

They advocate the development of sociability, interaction, intersubjective understanding, and communication necessary for treatment. It is aimed to do this without rejecting the third-person perspective. It is claimed that by adding these points to the treatment, the treatment will become personalised, comprehensive, transformative, effective, and efficient, and its success will increase. It is even claimed that the third-person perspective can solve important problems such as patients' non-compliance with treatment, resistance to treatment, and withdrawal from treatment during the treatment process. For all these, new methods are sought in which the expert will include his/her own subjectivity, subjective experience, and social structure in the process by combining them with his/her knowledge and insight, and these methods should be costless, easy, adaptable to medical education, and ethical.

Within the scope of the second perspective, the methods proposed for the third-person perspective, which will be explained in the next section (access to technological re-

sources and the expert's own internal resources), are very important for ensuring intersubjective communication, trust, and empathy. In addition, the widespread use of technological resources in practice and education may create new methods for the scientific investigation of the experiences of psychotics and alternative sources of technological treatment. Secondly, the practice of phenomenological psychiatry and the problems of first-person perspective dominance in the field have been discussed in the previous sections. Despite all these efforts in the literature, it is clear that this perspective does not have a scientific claim or a goal of treating the person. In this sense, the first-person perspective may be a toolbox containing a key and other tools, not a specific key to open a door. Therefore, claims that the first-person perspective cannot treat patients because it is not scientific would be meaningless because it is not a tool. This is because the first-person perspective, just like the biomedical symptom-based model, does not aim to treat people with definitive and permanent methods; on the contrary, it is based on the phenomenological method and adopts purely subjective experiences. It is not unexpected that such a perspective is not scientific. It would therefore be meaningless to criticise phenomenological psychiatry applied to psychotic patients simply because it does not have the results of the biomedical method.

Nevertheless, this point of view is not meaningless; the subjective processes, psychological, physiological, and bodily experiences of psychoses, and indeed of all other physical and psychological illnesses, are real and present in everyone. Some of these are of a nature and content that can be shared with other people through language; others cannot be expressed. This can create an insurmountable problem. In addition, among psychiatric disorders, psychoses are perhaps the group that experiences the phenomenological bodily process most differently. Because the perception of reality that only they have and the subjective experiences shaped within the scope of this definition, which cannot be shared with anyone else, constitute the phenomenal structure of the disease. Therefore, instead of trying to further scientise and objectify the first-person perspective (which would be completely meaningless for a view that embraces subjectivity), another approach can be chosen. Although the rigid, impermeable structure of subjectivity towards the person constitutes the qualification, its impenetrability can also lead to the failure to establish intersubjective relations. This barrier complicates not only the treatment but also the patient's daily communication.

Therefore, some methods can modify this subjectivity by manipulating its internalisation, even if it cannot be overcome externally. This can be done using virtual reality (VR), where professionals and families can know and understand what the patient's experiences are. As with the above goals, VR can be used in patient-expert or patient-family communication to share the same experience without subjectivity. In this way, the feelings, thoughts, vocabulary, and behaviours of the expert and the family related to the experience develop. If experts cannot cope with VR, they can use family support. Although the information that families have is not medical, it provides a wide range of information from who the patient is to what they do in their daily life practices. This can also be useful for traumatised patients who are unable to talk. A little information about the kind of person the psychotic is before the patient can provide a safe and solid basis for communication. Also, during simple psychoeducation, the family can be asked questions in the context of the patient. This provides an important source of information for the professional in cases where the person asks the patient but does not get an answer. In cases where this is not possible, looking at the patient's daily life practices and seeking a common ground of experience may be another option.

Consequently, the methods of softening and stretching the first point of view pass through the application of the second-person perspective. Since this practice will increase intersubjective interaction, the second-person perspective will be reinforced in the process, and subjective experience sharing will increase through social interaction. Softening these two perspectives and integrating them into the treatment by using different resources can be done with the following examples from the second-person perspective.

7.2.1. From the Clinic (Expert)

Preparatory Process: First of all, the specialist should be able to understand the patient's phenomenological process and the experience of the disease. Because in the beginning, the clinician needs to separate from the usual training process and remember that there is more than the patient's visible symptoms and behaviours. In this way, the specialist whose intersubjective awareness develops can initiate treatment.

a. Remembering:

Within the scope of Michael Paunen's second-person perspective requirement, the specialist should use his/her own internal resources and subjective process to understand his/her patient within the scope of Michael Paunen's three replication points. This can be realised in the context of their own subjective experiences. The biomedical symptom-based model has a rigid and hierarchical attitude that forgets the human side of the doctor and the fact that the patient will also be a patient. In contrast, the highly phenomenal reality of psychotic states is a problem for the patient and the expert. The psychotic person may not be able to express his or her personal needs, just as the doctor may not be able to reach the patient. Moreover, the epistemic priority of access to the experience of psychosis is open only to the psychotic person. The expert can therefore recall his/her own past experiences—and, if applicable, his/her own disease process—without violating ethical rules. Research shows that belief in the treatment of psychoses drops radically during the course of treatment (Karon, 2003). In this way, the relationship with the patient can become empathic, sincere, human, and meaningful. In addition, the experience of the specialist becomes a notion that facilitates meaning-making in situations and times when the patient cannot express themselves. Thus, the psychotic person feels understood and accepted, the treatment becomes personalised, and the patient's positive attitude towards the specialist, the treatment, and the process increases.

b. Use of Technology

The clinician may not have the appropriate experience for every situation and in some cases may not be able to use their own memories for ethical reasons. Indeed, video or virtual reality (VR) can be used to embody complex and difficult-to-articulate psychotic states. Embodying complex situations such as

Hallucinations and delusions with VR or videos enhance both the empathic process in treatment and the quality of scientific research. The treatment thus allows for personalised interventions. The resources used by the expert in the treatment are developed based on Paunen's replication. With these suggestions, the intersubjective

bond between the patient and the expert becomes strong, meaningful, and deep; the quality of the patient's self-expression increases, and the holistic method, which is missing in psychiatry, begins to develop by providing personalised treatment.

7.2.2. Other Experts

Psychiatry is a field with a rich intellectual environment that works together with other disciplines. On the other hand, the theoretical dimension of the bond that therapists develop with their patients, phenomenological concepts, different scientific suggestions, etc., should be shared with experts both within and outside the field. In this way, limited and narrow training, which is one of the weaknesses of first-person phenomenological psychiatry, can be prevented in this perspective. For this purpose, the method of joint intellectual attention developed by Claudia E. Vanney and J. Ignacio Aguinalde S´aenz and based on the second-person perspective can be used (2022). According to the method, at least two experts direct their joint attention and cognitive resources to an intellectual topic, question, or object and create a special attention called intellectual attention. This attention brings together experts with different education, experience, and backgrounds to form answers to difficult and complex problems. In the same study, it was emphasised that effective and important collaborations in interdisciplinary fields emerged with this attention. Thus, the complex aetiology, nosology, diagnosis, and treatment of psychosis can be discussed among different disciplines and professionals.

7.2.3. Patient Relatives

a. Psychoeducation

The inclusion of patients' relatives in the process is one of the points neglected by both first and third opinions in psychiatry. Despite this neglect, the positive attitude of patient relatives is one of the most important factors that play a role in the continuation of the treatment of psychotics (Eassom et al., 2014). According to another study, it was reported that psychoeducation given to the family in the early onset period made a positive difference (McFarlane, 2016). With simple psychoeducation,

family conflicts are prevented and the stress of psychosis on family members is reduced. This contributes positively to the treatment process. In this context, thanks to the simple psychoeducation to be given to the patient's relatives, the patient's intersubjective bonds with their relatives develop positively. The family does not follow the psychotic through his/her symptoms and evaluate him/her through observable behaviours; their experiences, insights, and empathy towards the disease increase positively thanks to their increased relationships. This develops in line with replication. The second point, the distinction between self and other, is also open to development in the patient's home environment. The basic level of psychoeducation provided to the family develops healthy reactions to the mental and emotional states of the patient and reinforces the self-limitations and different self-definitions of psychosis. In addition, the specialist can also use the family as an epistemological resource when they are unable to obtain information from the patient.

In addition, the involvement of the family and the close environment helps to understand the nature of the illness, and it is understood that conditions such as delusions and hallucinations are not dangerous but an internal experience of the patient. The transformation that starts with the family can also be used to avoid stigmatisation. In this way, the more understanding, supportive, and accepting the family is, the more the patient's relationship with the social environment can be reinforced. With the support of the psychotic family and social environment, whose self-limitations and definitions develop in a positive direction, they can understand that their mental and emotional states are different from others. Thus, the third condition, situational discrimination, will be strengthened.

Finally, second-person perspective skills and confidence developed over time also reduce comorbid disorders such as depression and anxiety in psychotics. These contributions support the patient's better adaptation to the treatment process, reduce family conflicts, and generally make the therapeutic process more effective. The second-person perspective enables a deeper relationship between the patient and relatives by centring empathy, meaning, and attachment mechanisms in this training process.

CHAPTER 8

CONCLUSION

In the near future, the power of artificial systems will increase exponentially and will penetrate into areas of society that have not been solved or used before. Again, contrary to what is expected and predicted, these developments will not only be driven by technological power but also by the increasing humanisation of these systems and methods. In other words, bringing science and philosophy together is among the developments expected to positively increase the evidence-based effects of different systems and modelling.

Psychiatry is one of the most important areas where science and philosophy intersect and is expected to act within frameworks such as personalised medicine and personalised psychiatry. Thanks to equipment such as artificial intelligence and machine learning, the foundations of which are laid today, it will further consolidate its power, influence, and place in the medical and therapy room in the future. However, for this to happen, the philosophy of psychiatry must also act in its own way. Different psychiatric illnesses, such as psychosis, where personalised, phenomenal experiences and states are called symptoms and are scientifically recognised as real, are today as enigmatic as artificial intelligence. On the other hand, the complex and fluid nature of human beings imposes an approach based on people of one type, one colour, one gender, and one economic class as the only truth, to the exclusion of the biomedi- cal symptom-based model, which is the dominant paradigm adopted by the modern medical system. This method acts from a third-person perspective in an objective, scientific, and systematic perspective. On the other hand, phenomenal psychiatry, which is one of the main models and methods put forward, does not suggest a treatment plan by showing a picture that prioritises subjective experiences and seeks the meaning of the patient's world. Therefore, it is subjected to criticism in the literature

precisely for this reason. Although the biopsychosocial model, which is proposed as the second example, tries to integrate the psychological and social projections of the patient into the process by following them, it is problematic because the frameworks adhered to are not defined. Therefore, it cannot be successful in providing a realistic result.

In the end, the winner of the friction between the first-person and third-person perspectives seems to be the biomedical symptom-based approach in the positivist world. However, this perspective and model are not sufficient. The second-person perspective proposed in this thesis starts a new endeavour by bridging the gap between the scientific and the philosophical view. This alternative perspective suggests an interpersonal dialogue in which the patient-carer-expert and other experts are involved in the medical approach in which scientific reality and truths are accepted. In this perspective, where empathy and listening are essential, the unbreakable and impenetrable subjectivity of the experience is tried to be softened with technological tools, and a common set of experiences is created. In this way, the expert understands the difficulty of subjective experiences that are dismissed as psychotic symptoms and adjusts the process according to the needs of the person. The expert can also create alternative epistemological resources in the process by using his/her own past experience and memory. In addition, interdisciplinary views, knowledge, and dialogues can be created in psychosis-specific interviews developed by other experts. In this way, specialists can break out of their own schools of thought, gain deeper insights into alternative worlds and knowledge, and discuss the big questions. Finally, the forgotten or neglected relatives of patients can be proactively involved in the process. In this way, an alternative method can be created to soften the patient's insurmountable and unbreakable subjectivity, as well as a safe environment in which the patient can apply what he/she has learnt in therapy.

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B. TURKISH SUMMARY / TÜRKÇE ÖZET

Üçüncü Şahıs Perspektifi ve Felsefi Psikiyatrinin Etkileri

Üçüncü şahıs bakış açısı, ölçülebilen ve gözlemlenebilen verileri kullanarak dış ve gözlemlenebilir kaynakların değerlendirilmesini içeren tıpta baskın bakış açısıdır. Yöntemler, kaynaklar ve içerikler bilimsel araştırmalarda kullanılır çünkü bilim doğası gereği ölçüme dayalı, deneysel ve gözlemseldir. Birinci şahıs bakış açısının aksine, ayrıcalıklı erişim söz konusu değildir. Aksine, belirli kriterleri karşılayan herkes üçüncü şahıs bakış açısına sahip olacaktır. Biyomedikal-semptom temelli yaklaşım da gözlemlenebilir davranış ve semptomlara, standartlaştırılmış tanı kriterlerine ve sınıflandırma sistemlerine odaklanmayı benimsemiş ve nesnelliği ön planda tutmuştur. Çünkü üçüncü kişi ile biyomedikal model arasındaki ilişkiyi Kopernik ve Newton'un mekanistik kozmos anlayışı üzerinden kurmaktadır. Weinert'e göre Kopernik ve Newton'un mekanistik kozmos anlayışı, evrendeki tüm olguların belirli yasalarla açıklanabileceğini ve dolayısıyla nesnel olarak değerlendirilip öngörülebileceğini iddia etmektedir. Kauffman ve Gare'e göre Descartes da bu anlayışla hareket etmiş ve beden ile beyin arasındaki süreçlerin bu temelde açıklanabileceğini düşünmüştür (2015). Dolayısıyla indirgemeci yaklaşımlar ile bilim ve tıp arasındaki nesnel değerlendirmeler arasındaki organik bağ da bu temelde kurulabilir.

Biyomedikal Semptom Temelli Modelin iddiaları aşağıdaki gibidir:

1. Tüm psikiyatrik hastalıklar nedensel olarak beyin yapısındaki anormalliklere veya nörotransmitterlerdeki dengesizliklere bağlanabilir ve böylece biyolojik kökenleri nedenselleştirilebilir.
2. Tüm psikiyatrik hastalıkların biyolojik temeli kabul edildiğine göre, beyin biyolojik olarak tedavi edilebilir. Bu nedenle tedavi, fiziksel hastalıkların tedavisiyle aynı mantığı izler.
3. Hastanın gözlemlenebilir şikayetleri ve semptomları, sistematik hale getirilen DSM gibi belirli çerçevelere ve tanı sistemlerine eklenir.

4. Modelin dışındaki alternatif yöntemlerin geçerliliği ve güvenilirliği zayıftır çünkü genellikle bilimsel geçerlilik ve güvenilirlikten yoksundurlar.

Psikiyatri Felsefesinde Biyomedikal Semptom Temelli Modelin Eleştirisi

Biyomedikal paradigma, hem sağlık sistemine hem de topluma sayısız katkı sağlamış bir modeldir. Biyolojik psikiyatriden türetilen bu kavram, ruhsal hastalıkların olumsuz etkilerinin ve toplumsal yükünün hafifletilmesinde önemli ilerlemeler sağlamıştır. Genetik ve biyolojik kökenlere dayanan biyolojik psikiyatri, zaman içinde DSM, beyin görüntüleme ve farmakolojik yöntemler gibi sistematik kaynakları benimsemiştir. Böylece üçüncü kişi bakış açısının temel görüşünü takip ederek daha objektif ve daha bilimsel açıklamalarla sistematik tedavi ve tanılar uygulamaya başlamıştır.Dolayısıyla biyomedikal model hem bireysel hem toplumsal hem de kamusal düzeyde avantajlı bir tedavi modeli sunmaktadır. Sonuç olarak, ruhsal bozuklukların kökeninde ve tedavisinde biyolojik nedenselliği septoma indirgeyen ve ilaçla çözmeye odaklanan biyomedikal model psikiyatride güç kazanmış ve evrensel olarak kabul görmüştür (Deacon, 2013). Böylece biyomedikal semptomatoloji, gözlemlenebilir davranışsal çıktılar, hasta ve yakınlarının sözel bildirimleri ve uzmanın kendi iç görüsü ışığında ruhsal bozuklukların tanı ve tedavi sürecinde bilimsel kesinliği hedefleyen bir tıp alanıdır.

Biyopsikososyal Model

Biyopsikososyal model, George Engel tarafından baskın biyomedikal modele karşı geliştirilmiştir ve hastaların değerlendirilmesinde bütüncül bir bakış açısını savunmaktadır (1981). Engel, çalışmasında biyolojik indirgemeciliğin sınırlı doğasını eleştirmiş ve alternatif bir uygulama modeli geliştirmiştir. Buna göre modelin adında da görüldüğü gibi insanların biyolojik, psikolojik ve sosyal etkilerini bir araya getirmeyi amaçlamaktadır. Ona göre hâkim model insanın psikolojik ve sosyal nosyonlarını göz ardı etmekte, bu da değerlendirme kısımlarında eksiklik ve uyumsuzluk yaratmaktadır. Dolayısıyla bu modelin savunucuları insan sağlığını sadece biyolojik bir mekanizmanın parçası olarak görmemekte; aksine insan sağlığını çevresel ve psikolojik faktörlerle etkileşim halinde olan bütün bir sistem olarak ele almaya çalışmaktadır.

Biyopsikososyal Modelin Psikiyatrik Uygulamaları

Bütüncül Bakış: Psikiyatrik çalışmalarda ve klinik alanda disiplinler arası bir yaklaşımı benimser ve teşvik eder. Böylece birden fazla değişkenin hasta üzerindeki etkisini en optimal şekilde anlamaya çalışır ve kapsamlı bir bakışaçısı sağlar. Bu sayede etiyolojik ve nozolojik çalışmalar daha bütüncül ve geniş bir perspektifte ele alınabilir. Bu durum, psikoz gibi karmaşık ve uygun tedavi konusunda fikir birliği bulunmayan hastalıklar için avantajlı olabilir.

1. **Hasta merkezli yaklaşım:** Baskın biyomedikal semptom modelinin uzman odaklı yaklaşımı yerine hastanın psikolojik yapısına vurgu yapan bir modeli benimser. Böylece biyolojik tedavilerin yanı sıra psikoterapi ve sosyal destek mekanizmaları da devreye girmektedir (Santos et. al., 2018).
2. **Klinik Uygulamalarda Çeşitlilik:** İlk iki yöntemin temelinde, çoklu yaklaşımları hasta odaklı bir bakış açısıyla birleştiren biyopsikososyal model, psikiyatrik tedavileri geniş bir perspektifte yapmaya çalışır. Böylece indirgemeci modellere ve üçüncü şahıs bakış açısının hakimiyetine meydan okur.
3. **Eşitlikçi Yapı:** Modelin bütüncül tavrı, hâkim paradigmanın belirlediği tanı, tanım ve sınıflandırmaların aksine farklı bir içerik sunar. Bu sayede ekonomik, sosyal ve kültürel dışlanmaya maruz kalan kişilerin tedaviye entegrasyonuna olumlu katkı sağlayabilir (Wittink vd., 2022). Ayrıca hâkim modelin tek tip mekanistik tedavisine erişemeyen bireyler için önerilir.

Psikiyatri Felsefesinde Biyopsikososyal Modelin Eleştirisi:

1977 yılında George Engel çok değerli ve önemli katkılarda bulunmuş ve mevcut tek tip, mekanik ve doğrusal organizasyona meydan okumuştur. Üstelik sunduğu model farklı zaman ve ortamlar için geliştirilmeye açıktı ve kişiye özel bir yapı sunuyordu. Bu sayede psikiyatrinin temel argümanlarının ve vurgularının değişmesi gerektiğini ve modern psikiyatride bir paradigma değişiminin zamanının geldiğini göstermesi nedeniyle psikiyatri ve felsefe alanında çok önemli bir konuma sahip olduğu ifade ediliyor ve bekleniyordu. Ancak böylesine önemli çıkışlar yapmış bir model günümüzde hala hakim psikiyatrik model olarak kabul görmemekte ve beklentileri karşılayamamaktadır (Deacon, 2013).

Teorik Sorunlar

Biyopsikososyal model güncel pratikte ve klinik uygulamada varlığını göstermeye çalışmaktadır. Faaliyet alanı biyo-psiko-sosyal paradigmaları kendi içinde birleştirerek ve yeniden yorumlayarak ele almaktadır. Ancak modelin felsefi temelde teorik sorunları vardı. Üstelik felsefi açıdan en çok pragmatizmle ilişkilendirilmiştir çünkü -yukarıda da belirtildiği gibi- hastaların acil ihtiyaçlarına ve işlevlerine göre şekillenmiştir. Ancak bu sorunları çözmek için yeterli değildir çünkü psiko-sosyal ve biyolojik yönlerin hangi perspektiften, neden, hangi içerikte ele alınacağı, hangi yöne öncelik verileceği ve bu etkileşimlerin objektif olarak nasıl ölçülebileceğine dair metodolojik bir temel veya çerçeve sunmamaktadır.

Epistemolojik Yetersizlik ve Pragmatik İndirgemecilik:

Modelde kullanılan faktörlerin hastayı ne ölçüde, hangi ilişki içinde, nasıl ve hangi içerikte etkilediğinin bilinmemesinin bir diğer sonucu da bu kavramlar arasındaki dengesizliktir. Özellikle psikotikler için gerekli olan bu bilgi, epistemolojik bütünlükten uzak bir şekilde deneme yanılma yoluyla hastaya uygulanmaktadır.

Epistemolojik Kaynak Uyumsuzluğu

Biyopsikososyal model, sağlık ve hastalık hakkında çıkarımlarda bulunmak ve kişiselleştirilmiş tedavi sağlamak için farklı bilgi ve kaynakları bir araya getirmeyi amaçlamıştır. Bu kaynaklar fiziksel veya nörobiyolojik, öznel deneyimler ve sosyal ilişkiler gibi unsurlardan oluşmaktadır. Ancak, bu bilgi kaynakları epistemolojik olarak bağımsız, ayrı ve uyumsuz olabilir.

Psiko- Sosyal Kavramının Anlam Sorunu

Bahsedilen sosyal ve psikolojik faktörler baskındır, ancak anlamları belirsiz ve açık uçlu görünmektedir. Hangi sosyal ve psikolojik faktörler tedaviyi etkilerdir? Tedaviyi etkilemeyen psikolojik faktörler var mıdır? Bu etkiler tanımlanabilir mi? Hastaların kültürü, karakteri, ekonomik yapısı, aile durumu ve eğitimi etkili olsa da, klinik etkileri

nasıl belirlenebilir? Psikolojik ve sosyal arasındaki ayrım nedir? Bu faktörler klinik tedaviye nasıl entegre edilebilir veya organize edilebilir? Bu konular, modelin psikolojik ve sosyal kavramları tanımlama, uygulama ve entegre etme konusunda sorunları olduğunu göstermektedir.

Gerçekçi Olmayan Hedefler

Sunulan modelin yol haritası, psikiyatrik ve fizyolojik hastaların biyolojik, psikolojik ve sosyal yönlerini tek ve entegre bir şekilde ele almayı amaçlamaktadır. Ancak, üçüncü madde bağlamında, klinik merkezlerin ve hastaların zaman ve kaynak kısıtlamaları bunu engelleyebileceğinden, bu gerçekçi bir beklenti ve hedef olmayabilir. Buna ek olarak, hastalar biyomedikal semptom temelli paradigmaya dayalı biyolojik tedavilerde olumlu sonuçlar aldıklarında psikososyal değişiklikleri takip etmeyecek veya dikkate almayacaktır.

Bilimsel Geçerlilik, Güvenilirlik, Objektiflik Sorunu

Önceki maddelerde ele alınan psikososyal faktörlerin ve değişkenlerin operasyonel tanımla tanımlanamadığı ve modelin yeterince nesnel olmadığı söylenebilir. Bu da modelde yer alan kavramların öznel olduğunu göstermektedir. Bu da yapının bilimsel ve objektif olduğu iddialarını zayıflatmaktadır. Yine üçüncü maddede belirtildiği gibi farklı disiplinlerin bir araya geldiği modelde teorik ve metodolojik uyumsuzluklar ortaya çıkmaktadır. Biyomedikal semptom temelli yaklaşıma karşı olduğu için takip ettiği tıbbi uygulamalar ve içerikler bilgi hiyerarşisinde psikolojik ve sosyal yaklaşımlara göre öncelenmektedir.

Felsefi Psikiyatride Birinci Şahıs Perspektifi

Michael Paunen'e (2012) göre birinci şahıs bakış açısı, kişinin kendi özel ve öznel deneyimsel, algısal ve duygusal kaynaklarını kullandığı bakış açısıdır. Bu perspektiften, kişinin kendisi hakkındaki bilgisiyle ilişkili olarak da algılanabilir ya da algılanır. Bu nedenle, bilinen kişinin perspektifi, diğer insanların ve kaynakların öznenin içsel sürecine erişilemezliği ile de ilgilidir. Dolayısıyla öznenin tek deneyim

sahibi olarak ayrıcalıklı konumunu öne sürer. Pauen'e göre kişinin kendisini bir bilgi kaynağı olarak görmesi ve bu durumun yalnızca kendisine açık olması, erişebildiği bilgi düzeyiyle ilgilidir. Örneğin, davranışsal açıdan, başının ağrıdığını söyleyen birinin sözlü ifadeleri fiziksel bir rahatsızlık içinde olduğunu gösterir. Ancak hiç kimse bu kişinin ağrılarını, sızılarını ve duygularını deneyimleyemez. Buna karşılık, birinci şahıs bakış açısında kişi kendisi hakkındaki bilgilere iki şekilde erişebilir. Kişi kendini anlık ve doğrudan öz farkındalık yoluyla deneyimleyebilir ya da geçmiş deneyimlerini hatırlayabilir (Zahavi, & Parnas, 1998). Dahası, epistemik erişim engelinin öznelliğin kırılamaz ve aşılamaz doğasıyla yakın bir ilişkisi vardır. Buna göre, kişi psikiyatrik hastalığı ve süreçlerini yalnızca kendisi deneyimler ve bu deneyim diğer tüm aktörlere kapalıdır.

Bu durum modelin iddia ettiği eşitlikçi yapıyı zayıflatmakta ve biyopsikososyal modeli biyomedikal modele her zamankinden daha yakın hale getirmektedir. Sonuç olarak, hastalık ve sağlığı eşitlikçi ve multidisipliner bir yapıda ele almaya çalışsa da, felsefi teori ve pratikte önemli sorunlar barındırmaktadır.

Psikiyatri felsefesinde birinci şahıs bakış açısının aktif kullanımı, daha önce de belirtildiği gibi, fenomenal yöntemlere ve fenomenolojik psikiyatriye dayanmaktadır.

Fenomenolojik Psikiyatri

Alternatif modellerin ikincisi ve sonuncusu olan fenomenolojik psikiyatri, psikiyatrik bozuklukları anlamak ve açıklamak için felsefeye, özellikle de fenomenolojiye dayanan bir yaklaşımdır ve 20. yüzyılda popüler olan biyolojik psikiyatriye ve argümanlarına karşı eleştirel bir duruş sergilemektedir (Larsen vd., 2022). Onlara göre bu yaklaşım, biyolojik psikiyatrinin ve onun gelişmiş modeli olan biyomedikal komşuluk temelli yaklaşımın bilimsel ve üçüncü şahıs bakış açısının aksine, öznel ve kişisel deneyimlere odaklandığı için birinci şahıs bakış açısına dayanmaktadır. Bu açıdan biyopsikososyal model gibi sağlık-hastalık ayrımı yapmaz ya da baskın model gibi bireyleri psikopatolojikleştirmez; bireylerin yaşamlarındaki sorunları varoluşsal bir şekilde ele alır ve dünya ile ilişkilerine odaklanır (Irarrázaval, 2020). Dolayısıyla, biyomedikal modelin pozitivist ve mekanistik doğasının, psikanalizin bilinçdışı

süreçlere odaklanması ve zamanının diğer ünlü yöntemleri gibi bunları bilimselleştirme çabasıyla tezat oluşturduğu anlaşılabilir. Sonuç olarak, fenomenolojik psikiyatrik psikanaliz biyolojik psikiyatriden ve biyopsikososyal modelden tamamen ayrı bir şekilde işler; insanları, davranışları ve durumları anormal-normal, patolojik-sağlıklı gibi iki kutuplu uçlar açısından tanımlamaz.

Fenomenolojik Psikiyatrinin Klinik Alandaki Etkileri

Felsefenin psikiyatriye sağladığı bu yeni ve özgürleştirici ortam, kuramsal çalışmalara önemli katkılar sağladı çünkü ilk kez psikiyatrik bozukluklar, egemen paradigmanın tanımladığı ve sınırladığı gibi sadece gözlemlenebilir komşuluklar olarak görülmüyordu. Hastalar farklı terminoloji, disiplinler ve bakış açılarıyla yeniden değerlendirilebildi. Böylece hastalar artık biyolojik bir sorun olarak görülmüyor ve yalnızca sahip olmalarına izin verildiği ölçüde ve anlamlarda sahip oldukları semptomları temelinde var olmuyordu. Bunun yerine, kişinin deneyimleyen bir özne olduğu fark edildi. Bu, biyomedikal model ile biyopsikososyal modelin ayrıştığı ilk noktaydı. Psikiyatrik bozukluklar, öznenin dünyayı anlamlandırma çabası içinde parçalanma gibi sorunlar yaşamasından kaynaklanıyordu. Bu nedenle hastalıklar biyolojik nedenlerle açıklanmıyor ve bir kez daha diğer iki modelden ayrılıyordu.

Fenomenolojik Psikiyatrinin Eleştirisi

Fenomenolojik psikiyatri, psikiyatride üçüncü şahıs bakış açısına ve onun temel modellerine felsefi temelli alternatif yaklaşımlar sunsa da, yeterli metodolojik zemin ve tutarlı uygulamalar sunmadığı için eleştirilmektedir. Öte yandan, bilimsel olarak kabul görmüş geçerlilik ve güvenilirlik süreçlerini dışladığı için bilimsel olarak yetersiz görülmektedir.Psikiyatride uygulanan yöntemler birinci şahıs bakış açısına dayalı, öznel ve fenomenolojiktir. Buna bağlı olarak öznel değerlendirmeler içeren raporlar da yanlıdır. Bunlar da bilimsel olmadığı için geçerli ve kalıcı bir çözüm sağlamaz.

Felsefi Psikiyatrinin İkinci Şahıs (2. şahıs) Perspektifi ve Etkileri

İkinci şahıs (2.) bakış açısı kaynak olarak 1. ve 3. şahıs kaynaklarla sınırlandırılamaz; bireyin zihinsel süreçlerini anlamak için öznelerarası ilişkisel

yönlere, sosyal etkileşimlere ve bağlamlara da odaklanır. Kendini sadece nesnel ya da sadece öznel yapılarla sınırlamadan hareket etmeyi amaçlar ve insanların anlam dünyalarını karşılıklı ilişkiler yoluyla aydınlatarak öznelerarasılık kavramına vurgu yapar (Fuchs, 2010). İkinci şahıs bakış açısı, doğası ve teknik yönleri nedeniyle psikiyatrik bozuklukların tanı ve tedavisinde kullanılması önerilen bir bakış açısıdır (Fuchs & Dalpane 2022). Öznelerarasılık ve ikinci şahıs bakış açısı Schilbach tarafından da özellikle psikoz gibi öznel deneyimlerin sürece dahil olduğu ampirik vakalarda ve farklılaşmaya yönelik bilimsel gerekçelendirmelerde önerilmektedir (2016).

İkinci Kişi Perspektifinin Psikoza Uygulanabilirliği

İkinci Kişi Perspektifine Dayalı Tedavinin Teorik İlkeleri: Michael Paunen'in Üç İlkesi

Michael Paunen, çoğaltma, ben-öteki ayrımı ve durumsal ayrımın ikinci şahıs bakış açısının temel ilkeleri olduğunu savunmaktadır. Bunlara dayanarak, ikinci şahıs perspektifi diğer perspektiflerden ayırt edilebilir, diğer öznelerle etkileşimlerin dinamik yapıları, içerikleri, özneler arası anlamları ve bağlamları anlaşılabilir ve terapötik, bilimsel ve etik uygulamalar için bir temel oluşturulabilir (2012). Bu üç ilke, özellikle psikotiklerin tedavisinde, aynı zamanda gelecekte farklı hasta türleri için kullanılabilecek alternatif kaynakların tartışılmasında ve hiyerarşik tanı kaynakları içinde tanısal çıkarımların tartışılmasında bir rehber olarak kullanılabilir.

Çoğaltma

Kişinin kendi öznel kaynakları başkalarının zihinsel durumlarını anlamak için kullanılır. Bunlar deneyimler ve hayal gücüdür. Pauen'e göre, çoğaltma için kullanılan kaynaklar onu üçüncü şahıs perspektifinden ayırır çünkü indirgemeci yöntem zihinsel durumları nesnel veriler ve teorileştirme açısından açıklar. İkinci şahıs bakış açısında kişi geçmiş deneyimlerini kullanır. Eğer hastanın bu anlamda bir deneyimi yoksa kişi böyle bir durumun nasıl olacağını, nasıl hissedeceğini hayal eder ve hayal gücünü kullanır.

Ben-Öteki Ayrımı

Ötekinin sahip olduğu düşünce ve duygusal süreçlerin öznede de mevcut olabileceği gözlemlenmişti. Ancak, öznenin hayal ettiği veya önceki deneyimlerinden hatırladığı durumların birine ait olduğunu fark etmesi de gerekir; bu taklit etmenin çok ötesindedir. Buradaki kilit nokta, başka bir kişinin zihinsel içeriklerinin ve duygusal süreçlerinin kendisine ait olduğunun farkına varılmasıdır ve bu durum biliş, benlik ve öteki arasındaki ayrımı net bir şekilde başlatacaktır. Öznenin başka özneler olduğuna dair algısı öznelerarası durumun temelini oluşturur.

Durumsal Ayrım

Kişinin kendi kaynaklarını kullanarak bir başkasının zihinsel/duygusal sürecini deneyimleyebileceğini veya taklit edebileceğini göstermiştir. Ayrıca, kişinin anlamak istediği zihinsel/duygusal süreçlerin kendisine değil, başka bir özneye ait olduğunu açıkça fark etmesi gerektiğine dikkat çekmiştir. Bunun için bireyin kendi durumunun farkına varması ve başkalarının durumundaki farklılıkları açıkça anlaması gerekir.

İkinci Kişi Perspektifinin Psikoz İçin Uygunluğu

Psikozun kendine özgü zor durumu, replikasyon, ben ve öteki arasındaki ayrım ve sosyal ayrım kavramlarının sorunlu deneyiminde de gözlemlenebilir. Özellikle paranoid sanrılar gibi epizotların içeriğinde, hastalar kendi öznel düşüncelerini/duygularını başkalarına atfeder, onları düşünür ya da hayal eder ve taklit ederler. Yine psikotik paranoyak, paranoid duygu içeriklerini kendi duyguları olarak görmeyerek diğer insanlara yansıtır. Ya da hastalar aktif epizodlar sırasında diğer insanların görüş, değerlendirme ve bakış açılarındaki farklılıkların farkında değildir. Benzer şekilde, halüsinasyonların veya sanrıların diğer insanları korkuttuğunu fark etmeyebilirler veya kendilerinin bir tehdit oluşturmadığını ifade etmekte zorlanırlar. Bunlar, Pauen'in ikinci şahıs bakış açısına dayanan kavramlarla ilgili sorunlara örnektir. Psikotik hastaların her üç ilkesi de sorunluysa, ikinci şahıs bakış açısı işleyişlerini, benlik ve beden deneyimlerini ve diğer insanlarla olan ilişkilerini ve iletişimlerini etkileyecektir. Sonuç olarak, bu perspektif psikotiklerde birinci ve

üçüncü şahıs perspektiflerine kıyasla belki de daha belirgindir. Hakim paradigmanın ve alternatif olarak sunulan diğer uygulamaların sorunlu durumları anlamakta yetersiz kalmasının nedeni bu olabilir. Böylece psikiyatri hastaları, özellikle de psikotik hastalar, en uygun tanı ve tedaviden mahrum kalmaktadır. Aşağıda, bu sorunlardan kaçınmak için bazı tedavi önerileri verilmektedir.

Felsefi Psikiyatrinin İkinci Şahıs (2. şahıs) Perspektifi ve Tedavi Önerileri

Klinikten (Uzman)

Hazırlık Süreci: Her şeyden önce uzman, hastanın fenomenolojik sürecini ve hastalık deneyimini anlayabilmelidir. Çünkü başlangıçta klinisyenin olağan eğitim sürecinden ayrılması ve hastanın görünür semptom ve davranışlarından daha fazlası olduğunu hatırlaması gerekir. Bu şekilde öznelerarası farkındalığı gelişen uzman tedaviyi başlatabilir.

1.a Hatırlama

Michael Paunen'in ikinci şahıs bakış açısı gerekliliği kapsamında uzman, Michael Paunen'in üç çoğaltma noktası kapsamında hastasını anlamak için kendi iç kaynaklarını ve öznel sürecini kullanmalıdır. Bu, kendi öznel deneyimleri bağlamında gerçekleştirilebilir. Biyomedikal semptom temelli model, doktorun insani yönünü ve hastanın da bir hasta olacağı gerçeğini unutan katı ve hiyerarşik bir tutuma sahiptir. Buna karşılık, psikotik durumların son derece fenomenal gerçekliği hasta ve uzman için bir sorundur. Psikotik kişi kişisel ihtiyaçlarını ifade edemeyebilir, tıpkı doktorun hastaya ulaşamayabileceği gibi. Dahası, psikoz deneyimine erişimin epistemik önceliği sadece psikotik kişiye açıktır. Bu nedenle uzman, etik kuralları ihlal etmeden kendi geçmiş deneyimlerini -ve varsa kendi hastalık sürecini- hatırlayabilir.

1.b Teknoloji Kullanımı

Klinisyen her durum için uygun deneyime sahip olmayabilir ve bazı durumlarda etik nedenlerle kendi anılarını kullanamayabilir. Gerçekten de video veya sanal gerçeklik

(VR), karmaşık ve ifade edilmesi zor psikotik durumları somutlaştırmak için kullanılabilir. Aşağıdaki gibi karmaşık durumların somutlaştırılması VR veya videolarla halüsinasyonlar ve sanrılar hem tedavideki empatik süreci hem de bilimsel araştırmanın kalitesini artırır. Tedavi böylece kişiselleştirilmiş müdahalelere olanak tanır. Uzman tarafından tedavide kullanılan kaynaklar Paunen'in replikasyonuna dayalı olarak geliştirilmiştir. Bu önerilerle hasta ve uzman arasındaki öznelerarası bağ güçlü, anlamlı ve derin hale gelir; hastanın kendini ifade etme kalitesi artar ve kişiye özel tedavi sağlanarak psikiyatride eksik olan bütüncül yöntem gelişmeye başlar.

Diğer Uzmanlar

Psikiyatri, diğer disiplinlerle birlikte çalışan, zengin bir entelektüel ortama sahip bir alandır. Öte yandan terapistlerin hastalarıyla geliştirdikleri bağın kuramsal boyutu, fenomenolojik kavramlar, farklı bilimsel öneriler vb. hem alan içinden hem de alan dışından uzmanlarla paylaşılmalıdır. Böylelikle birinci şahıs fenomenolojik psikiyatrinin zaaflarından biri olan sınırlı ve dar eğitimin bu perspektifte önüne geçilebilir. Bu amaçla Claudia E. Vanney ve J. Ignacio Aguinalde S´aenz tarafından geliştirilen ve ikinci şahıs bakış açısına dayanan ortak entelektüel dikkat yöntemi kullanılabilir (2022). Yönteme göre, en az iki uzman ortak dikkatlerini ve bilişsel kaynaklarını entelektüel bir konuya, soruya veya nesneye yönlendirir ve entelektüel dikkat adı verilen özel bir dikkat oluşturur. Bu dikkat, farklı eğitim, deneyim ve geçmişe sahip uzmanları bir araya getirerek zor ve karmaşık sorunlara yanıtlar oluşturmaktadır. Aynı çalışmada bu dikkat sayesinde disiplinler arası alanlarda etkili ve önemli işbirliklerinin ortaya çıktığı vurgulanmıştır. Böylece psikozun karmaşık etiyolojisi, nozolojisi, tanı ve tedavisi farklı disiplinler ve profesyoneller arasında tartışılabilir.

3.Hasta Yakınlarına Psikoeğitim

Hasta yakınlarının sürece dahil edilmesi, psikiyatride hem birinci hem de üçüncü görüşlerin ihmal ettiği noktalardan biridir. Bu ihmale rağmen, hasta yakınlarının olumlu tutumu psikotiklerin tedavisinin devam etmesinde rol oynayan en önemli faktörlerden biridir (Eassom ve ark., 2014). Bir başka çalışmaya göre, erken başlangıç

döneminde aileye verilen psikoeğitimin olumlu bir fark yarattığı bildirilmiştir (McFarlane, 2016). Basit psikoeğitim ile aile içi çatışmalar önlenmekte ve psikozun aile üyeleri üzerindeki stresi azaltılmaktadır. Bu da tedavi sürecine olumlu katkı sağlamaktadır. Bu bağlamda hasta yakınlarına verilecek basit psikoeğitim sayesinde hastanın yakınları ile özneler arası bağları olumlu yönde gelişir.Bu da replikasyon doğrultusunda gelişir. İkinci nokta olan ben ve öteki ayrımı da hastanın ev ortamında gelişmeye açıktır. Aileye verilen temel düzeydeki psikoeğitim, hastanın zihinsel ve duygusal durumlarına karşı sağlıklı tepkiler geliştirir ve psikozun öz sınırlamalarını ve farklı öz tanımlarını pekiştirir. Ayrıca uzman, hastadan bilgi alamadığı durumlarda aileyi epistemolojik bir kaynak olarak da kullanabilir.Buna ek olarak, ailenin ve yakın çevrenin katılımı hastalığın doğasını anlamaya yardımcı olur ve sanrılar ve halüsinasyonlar gibi durumların tehlikeli değil, hastanın içsel bir deneyimi olduğu anlaşılır. Aile ile başlayan dönüşüm, damgalanmayı önlemek için de kullanılabilir. Bu şekilde aile ne kadar anlayışlı, destekleyici ve kabul edici olursa hastanın sosyal çevreyle ilişkisi de o kadar pekiştirilebilir. Kendini sınırlamaları ve tanımlamaları olumlu yönde gelişen psikotik aile ve sosyal çevrenin desteği ile zihinsel ve duygusal durumlarının diğerlerinden farklı olduğunu anlayabilir. Böylece üçüncü koşul olan durumsal ayrımcılık güçlenecektir.

Sonuç olarak, birinci şahıs ve üçüncü şahıs perspektifleri arasındaki çekişmenin galibi, pozitivist dünyada biyomedikal semptom temelli yaklaşım gibi görünmektedir. Ancak bu model de yeterli değildir ve önerilen ikinci şahıs bakış açısı, bilimsel ve felsefi yaklaşımlar arasındaki boşluğu doldurarak yeni bir çaba başlatmaktadır. Bu alternatif yaklaşım, bilimsel gerçeklikleri kabul eden tıbbi yaklaşımla hasta-danışan- uzman ve diğer uzmanlar arasında kişiler arası bir diyalog önerir.Empati ve dinlemenin esas olduğu bu yaklaşımda, deneyimin kırılmaz ve aşılmaz öznelliği, teknolojik araçlarla yumuşatılmaya çalışılır. Böylece ortak bir deneyim bütünü oluşturulabilir. Uzman, psikotik semptomlar olarak nitelendirilen öznel deneyimlerin zorluğunu anlayarak süreci kişinin ihtiyaçlarına göre ayarlayabilir. Ayrıca, kendi geçmiş deneyim ve hafızasını kullanarak alternatif epistemolojik kaynaklar yaratabilir. Bu yaklaşımın bir diğer önemli yönü, disiplinler arası görüşlerin oluşturulmasıdır. Psikoza özgü görüşmelerde farklı disiplinlerden gelen uzmanlar bir araya gelerek alternatif dünyalara ve bilgilere dair derin içgörüler kazanabilir, büyük soruları tartışabilir.

Hasta yakınları da sürece proaktif bir şekilde dahil edilerek, hastanın öznelliğini yumuşatacak, terapide öğrendiklerini uygulayabileceği güvenli ortam yaratılabilir.

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