Dear delegates,

We would like to draw your attention to this manifest which seems to be of great importance for the ongoing discussion on the value of clinical view on psychological symtoms in contrast to a psychiatric/ statistical approach to mental suffering. It supplies you with arguments in favor of clinical diagnostic criteria as the sole criterion in the clinic of psychological symptoms.

Best wishes,

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Chair of EFPP

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MANIFEST FOR A CLINICAL NON-STATISTICAL PSYCHOPATHOLOGY

By this manifest, the undersigned professionals and institutions, want to declare ourselves in favor of clinical diagnostic criteria, and therefore against the imposition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as the sole criterion in the clinic of psychological symptoms. We would like to share, discuss and agree on the clinical knowledge -*logy*- on mental *pathos*, understood as symptomatic suffering, and not a disease. We wish to question the existence of mental health, statistical or normative, as well as the clinical and intellectual imposture of the notion of mental disorder or mental illness. We also want to denounce the imposition of one sole therapy treatment for typified disorders. These being formatted to the detriment and contempt of other theories and treatment strategies, as well as the contempt of the patients' right to choose. At present, we witness how clinical practice is becoming less dialogist and more indifferent to the manifestations of mental sufferings, clinging to the protocols and palliative treatments, which only address the consequences, but not their causes.

As stated by G. Berrios (2010) "We are facing a paradoxical situation in which clinicians are asked to accept a radical change in the way of developing their work, (ie leave the advice of your own experience and follow the dictates of statistical and impersonal data) when in fact, currently, the basis that are used for evidence are no different than what the statistics, theorists, managers, companies (such as the Cochrane Institute) and capitalist investors say, being these who precisely say where you put the money." We thus want to uphold a health model, where the speech is a value to promote and where each patient is considered in its particularity.

The defense of the subjective dimension entails to value and consider what each one brings into play to address what remains unbearable, stranger to oneself, but yet familiar. We express our rejection to the welfare policies which prioritize security at the expense of freedom and human rights. Policies that, under the guise of good intentions and the search for the good of the patient, reduce the patient to a performance calculation, a risk factor or a vulnerability index which ought to be removed, nearly by force.

For any discipline, the approach to the reality is done through a theory. But this limited knowledge should not be confused with *The Truth.* This would act as an ideology or religion, where any thought, event, or even the used language would serve to promote the *re-ligare*between knowledge and truth. Any clinician with a true scientific spirit knows that his theory is what Aristotle called an *Organon*, that is a tool to approach a reality, which becomes always more plural and changeable, and whose categories are only an

expression of its diversity, making it become wider from both a theoretical and practical perspective.

This conception is opposed to the idea of a *canon*, in the sense of what necessarily things are and that they must perform in a certain way. We all know the consequences of this kind of position that goes from being indicative to set a rule and become prescriptive, and ultimately coercive. This is where knowledge becomes the exercise of a power that sanctions as per what obeys or disobeys this *canon*. It also means the subordination of subjectivity to the management of social order, as per what markets demand. Everything is for the patient but without taking the patient into consideration. We know that any knowledge dismissing the subject constitutes an act of power on this subject. J. Peteiro calls it "*scientific authoritarianism".* For all this, we want to express our opposition to the existence of *a Sole, Compulsory and Universal Diagnosis Code*.

Furthermore, the a-theoretical model that the DSM boats about, claiming to guarantee any objectivity, only talks about his epistemological failure. Suffice is to recall its inability to define what a mental disorder and mental health are. The contents of this psychiatric taxonomy respond more to political reasons and agreements than to clinical observations, leading to a very serious epistemological problem.

Regarding the classification method applied at the DSM, we find that even though many things can be sorted, stacked or grouped, there is no nosographic entity that can be established in a given field. Finally, and in the same line as above, the statistics used in the DSM have a weak point of origin: the ambiguity of the object on which it operates, that is, the concept of mental disorder. Statistics are presented as a technique, a tool that can be used for multiple causes, of any kind. Items and basic values of the statistical curve are handled by persons, and they are responsible to quantify and interpret the data.

In this context of poverty and confusion, the forthcoming DSM-V constitutes a clear threat: no one is sheltered from what is fixed as illness. There is no room for health in terms of change, mobility, complexity and multiplicity of forms. All of us are patients and we all suffer from a disorder. Any manifestation of discomfort will be quickly transformed into symptoms of an illness that needs to be medicalized for life. This is the big leap that has been done without any epistemological net: from prevention to the prediction. Frances Allen, head of Task Force of the DSM IV, warn us in his article "*Opening Pandora's box*" about lower diagnostic thresholds for many existing or newly diagnosed disorders that could be extremely common in the general population. He also lists some of the new conditions that are to be included within the DSM-V: the *risk of psychosis syndrome* ("It is certainly the most disturbing suggestion. The false positive rate would be alarming, going from 70 to 75%"). *The mixed depressive anxiety disorder*. *Minor cognitive disorder* ("is defined by specific symptoms ... the threshold has been arranged to include a massive 13.5% of the population".) *Binge eating disorder*. *Dysfunctional disorder character with dysphoria. Paraphilic coercive disorder. Hypersexuality disorder, etc.*As a result, it does not only increase the number of disorders but also the semantic field of many of them, as it is in the case of the ADHD. The DSM-V promotes a diagnosis based on the sole presence of symptoms, and doesn't entail any disability. Furthermore, it reduces to the half the number of symptoms required for adults. The diagnosis of ADHD is also provided in the presence of autism, which would involve creating two false epidemics and would foster an increased use of stimulants in a particularly vulnerable population.

If we combine these statistics with the heterogeneity thematic working groups that have proliferated, ranging from *gender identity, through the adaptation of the pulse, hyper-sexuality, mood swings* etc., we cannot ignore the pursuit of a full autonomy with respect to any theoretical framework and any epistemic rigor control by the international classifications. We, nevertheless, do not believe that the classifications and treatments

can be neutral with respect to etiology theories, as it is intended. They can neither be neutral with respect to the ideology of *social control*, and other extra-clinical interests.

Paul Feyerabend, in "*The Myth of Sscience and its Role in society"*, writes: "Basically, there is hardly any difference between the process leading to the formulation of a new scientific law and the process that precedes a new law in society " It seems, continues this author in "*Farewell to Reason"* that: "The world we live in is too complex to be understood by theories that obey to epistemological (general) principles. And scientists, politicians, -anyone trying to understand and / or influence the world and, taking into account this situation,- are violating universal rules, abusing of developed concepts, distorting the knowledge already obtained and constantly thwarting attempts to impose a science, in the sense used by our epistemologists*.* "

Finally, we would like to draw attention to the danger it involves to the treatment of psychological symptoms the fact that new clinicians are deliberately educated in the ignorance of classical psychopathology. Clinical psychopathology responds to the dialectic between theory and clinical practice, between knowledge and reality, but it is no longer taught at our universities. And yet, they are instructed in the paradigm of a pharmacologic approach that has become universally prescriptive for everybody and for any condition. It is not much different from a label vending machine, which restocks medication. What we denounce is the complete ignorance of the foundations of psychopathology, a fundamental tool when exploring patients and, consequently, a considerable constraint when making a diagnosis.

Since knowledge may the most ethical way for approaching our plural reality, the coexistence of different theories about the complexity of human beings should be respected.

Therefore, we propose to take actions in order to stop the increasing spread and growth of international classifications, and alternatively work with classification criteria which are based on psychopathology fundamentals and exclusively stem from the clinical practice.

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