Fundamental Psychopathology: contribution to a democratic society.*

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Abstract

This article consists of a reflection on the need for a psychopathology that takes subjectivity into consideration and that is influenced by the practices developed in the wake of the Brazilian Psychiatric Reform. These practices, non-existent in the past, are designed to absorb psychiatric patients into civil and democratic society. For this to happen, however, it is not enough to simply close down the country's insane asylums, its mental hospitals. Clinical narratives must also be produced that describe the inroads that have been made in the treatment of mental disorders. Such narratives should address what is known as the *clinical method*. In other words, they should describe the history of each type of treatment and afford deeper knowledge in the area of caring for the persons involved.

Keywords: Fundamental psychopathology, subjectivity, Brazilian Psychiatric Reform, clinical method

Article

Fourteen years ago, in February 1995, the Laboratory of Fundamental Psychopathology was founded as part of the Graduate Study Program in Clinical Psychology at the Catholic University of Sao Paulo, Brazil. A year later, in April 1996, the University Network for Research in Fundamental Psychopathology was organized, which, later, in 2002, took on the name of the University Association for Research in Fundamental Psychopathology.

By early 2009 this international scientific society comprised 52 university professors with doctoral degrees. Some were associated with 22 different Brazilian universities and others were working in universities in Argentina, Colombia, Mexico, France and Great Britain.

The University Association for Research in Fundamental Psychopathology publishes two journals of international standards: its official organ, the *Latin-American Journal of Fundamental Psychopathology*, which is published in both printed and Internet forms, and the *Latin-American Journal of Fundamental Psychopathology Online*, its official organ on the web.

Every two years an International Congress of Fundamental Psychopathology and a Brazilian Congress of Fundamental Psychopathology are held, with the tenth

congresses already scheduled for 2010 at the Federal University of Paraná, in Curitiba, PR, Brazil. Its central theme will be "Love and its disorders."

The Association also collaborates with the *Library of Fundamental Psychopathology*, a series of books put out by Editora Escuta Publishers.

The area of fundamental psychopathology takes the term "psychopathology" very seriously. Etymologically the word means discourse (logos) on pathos (affects, suffering, emotions, etc.). The term "fundamental" is used to distinguish this approach from general psychopathology, a field of study inaugurated through a book of the same name by Karl Jaspers, in 1913 (Jaspers, 1987).

General psychopathology derives from a philosophical tradition based on the Enlightenment and on the rationalism inaugurated by Kant, of whom Jaspers is considered a renowned disciple. *Fundamental psychopathology*, in contrast, deals with the long, broad and complex discourse (logos) that takes subjectivity into consideration (Arendt, 2008).

This does not mean that fundamental psychopathology runs contrary to the objective and rationalist tradition, since it recognizes the need for the broadest possible dialogue among the diverse psychopathologies. This position is based on the pre-supposition that there is no single discourse that can fully encompass the question of mental suffering.

After the Laboratory of Fundamental Psychopathology was founded at the Catholic University of Sao Paulo, a number of Latin-American scholars who were doing doctoral work at the University of Paris 7 – Denis Diderot, with Dr. Pierre Fédida as their advisor, returned to their own countries and began setting up similar programs for teaching and doing research in fundamental psychopathology. In addition, Dr. Fédida himself had come regularly to Brazil since 1976 to work with groups of psychologists, psychiatrists, philosophers and psychoanalysts, despite the country's military regime. Fundamental psychopathology therefore went through a process of international dissemination that is still going on today.

Before the Laboratory of Fundamental Psychopathology was founded and the First Brazilian Congress of Fundamental Psychopathology was held, the teaching of psychopathology in Brazilian universities was dominated by Karl Jaspers's general psychopathology, in conjunction with the DSM and the CID. This approach to psychiatric practice is based on manuals of psychiatry that, as is common knowledge, tend merely to summarize research and writings already produced.

With the introduction of fundamental psychopathology, it became clearer that both the DSM and the CID are complex systems of classification of mental disorders based on standardization and generalization. This perception gradually resulted in a number of studies and the publication of articles about the various limitations contained

in these manuals. Their efforts at standardizing and generalizing mental disorders ignore both the subjective dimension and the singularity proper to the human species. By taking this approach, these publications eliminate the idea of a discourse (logos) on mental suffering. In other words, they ignore the specific characteristic of psychopathology itself. The characteristics of these classification systems comply, primarily, with certain interests (of professional associations such as the American Psychiatric Association, the pharmaceutical industry, health insurance companies and, finally, the interests of governments in their attempt to reduce the costs of their mental health programs). These organizations show no specific concern with either singularity or subjectivity.

From this point of view, the scientific truth proper to psychopathology is fully contained in these classification systems and manuals of psychiatry, and there is no need for further research on mental suffering in order to delve more deeply into factors that are ignored by these protocols. They thus create a silence in psychopathology, allied to the general conviction according to which the entire field is contained in them.

But this is nothing new.

Since Ancient Times, such as in Ancient Greece, there were two types of medicine. Plato, in *The Republic*, describes medicine for slaves and foreigners, on the one hand, and medicine for citizens, on the other. The medicine for slaves and foreigners was silent, since foreigners spoke strange languages, and slaves, by definition, said nothing. In this type of practice doctors would examine patients and, using their active memory through the process known as anamnesis, would diagnose the disorder and consequent suffering. In contrast, the medicine for citizens was based on the word, on speech. With this approach, the patients were recognized as members of the city-state. They were citizens and could describe their illnesses to the doctor. The doctor, in turn, listening to the patient's account, would make use of his passive memory (mnemosyne) and treat the patient accordingly (Plato, 2000; Ricoeur, 2007).

At another point occasion during *The Banquet,* Plato describes medicine through the mouth of the physician Eriximaco, as the art of dealing with the phenomena of love. "In short," Eriximaco says, "this is medicine for talking about the science of the phenomena of love, proper to the body" (Plato, 2001).

The physician was constantly in relationship with love because physical diseases, in their evolution, were seen as emotions related to love. The physician took care of sick Eros. By re-establishing the balance of the body, Eros, ill from too much love, could thus be freed from this excess through the love that the physician would bring him. A physician’s love physician was fair love. It established a counterpart, a new balance, with the sick part of Eros (Fédida, 1988).

From this perspective, it should be recalled that the terms "medicine" and "medical doctors" existed long before there were medical schools and regulations set down for the profession by the modern State.

Secondly, we should recall that *The Banquet* is a symposium in honor of Eros, the first of the Greek gods. At this symposium all those present rendered homage to Eros, a powerful divinity admired by both men and gods, for a number of reasons, especially the unique situation of his birth. The fact that he was the oldest of the gods gave him exceptional prerogatives, in the opinion of Phaedrus, one of the participants at the symposium.

Eros was also powerful and admirable because he dedicated himself to making connections. It might be recalled that, since Parmenides, Heraclitus and others, two types of love were considered. There was popular love, that is, love with its physical excesses, and celestial love, which was related to the correctness of words, the correctness of logos. One cannot exist without the other (Fédida, 1988).

Also according to Eriximaco, the desire that moves medical care (as well as gymnastics and music) is to re-encounter harmony, harmonious sound, in other words, sounds that are not consonant but from whose association some harmony can be created. Under these conditions, the problem of love is seen in relation to the equilibrium of rhythm and in relation to the problem of eating.

Reading *The Banquet* is a true adventure of the spirit. One can conclude from it that a physical disorder is not only a disorder of love. In addition it can only be cared for if the doctor – as therapist – introduces the just proportion of love.

There is no reason to reject this conception today. On the contrary, as I have asserted on other occasions, the term psychosomatics should be replaced by the expression somatic psychopathology (Berlinck, 2000). Psychosomatics reintroduces the problem of the influence of the psyche on the soma, or of the soma on the psyche, without taking into account the breadth of the term "psychopathology." In the tradition of the poet Aeschylus (it would be interesting to read his play *Agamemnon*) the expression "*pathei mathos"* is used to indicate what is pathetic, what affects one emotionally, what is lived through and can become experience. In German the corresponding words are *erleben* (to witness, to observe) and *erfahren* (to experience). Literally, psychopathology means suffering that bears within itself the possibility of some internal learning. As emotion it becomes a test and, as long as someone else hears it, it has the power to heal. This immediately brings up the position of the therapist. An emotion cannot teach anything. On the contrary, it leads to death if it is not heard by what is outside, by what is foreign, by someone who can care for it (Fédida, 1988).

The indiscriminate use of classification systems aimed at standardization and generalization do away with the words of those who undergo mental suffering and encourage medicine for slaves, where the word of the other does not exist, since it is totally inaccessible.

Certainly, classification systems like the DSM and the CID have their value,

especially their relative precision of diagnosis, savings in time for medical consultations, and reduction in the costs of medical services.

But in societies where the great majority of the population have no channels where they can talk and be heard about their psychic suffering, the standardization and generalization of the classification systems run the risk of feeding the authoritarianism and silence they live under, thus strengthening medicine for slaves and foreigners.

In this regard it is important to recall the words of Georges Canguilhem in *Writings on medicine* (2005):

> “Doctors are not far from thinking that their science has a language reserved to them alone, while their patients speak in jargon. But in the beginning, doctors were men living in an age when they were not sure whether they would become gods, desks or basins. They have thus conserved recollections of the original block from which they were sculptured and, in principle, have retained aspects of the jargon they disdain in their scientific language. They may occasionally consent to understand that the demands of their patients may be limited to maintaining a certain quality of the disposition to live or attain its equivalent, without being concerned about whether the objective tests for treatment are positive and in agreement with one another” (p. 58).

So in 1995 the long and variegated tradition of psychopathology in medicine was in a terminal state due to the generalized and mechanical use of technologically standardized classification systems and manuals designed to "contain all" medical knowledge through summaries of what is already known. Almost all schools of medicine and psychology limited themselves to the teaching of these classification systems under the heading of "psychopathology."

The rise of fundamental psychopathology began to revert this situation, which has also been strongly affected by yet another phenomenon that took place in Brazil during the late 1980s and early 1990s, namely, the Brazilian Psychiatric Reform, a vast program to change the country’s public mental health policies.

This reform consists of a movement within in the sphere of public health, and became consolidated through legislation on mental health based on the Declaration of Caracas. This document was approved by acclamation at the Regional Conference for Restructuring Psychiatric Treatment in local health systems.

Brazil signed this declaration and put it into practice following a long and turbulent movement led ahead by mental health workers. The result was Law No. 9867, of November 10, 1999, and then became possible to set up and develop psychosocial support programs for psychiatric patients, who could thus be treated at specialized

community outpatient health centers. This is a valuable instrument for putting treatment into concrete practice and for including these patients into the dynamics of the economic and social facets of everyday life. There is a clear analogy with the so-called "social companies," an important element of the Psychiatric Reform in Italy.

On April 6, 2001, the Brazilian Federal Government promulgated Law No. 10.216, which legislated on the protection and rights of persons with mental difficulties, and reformulated the model for mental health services. This text reflects the consensus that was possible at the time for legislation related to Brazil's psychiatric reform. The law was based on a legislative bill originally drawn up by Congressman Paulo Delgado, and includes propositions that modify the original draft.

The law reorganized the model of public psychiatric care, regulated the care and treatment to be afforded to patients who had been committed to hospitals for many years, and called for punishment in cases of involuntary arbitrary or unnecessary hospitalization.

On May 28, 2003, the president of Brazil established an Interministerial Work Group to evaluate and present proposals for revision, propositions and discussions of the government's policies for treating alcohol abusers and to harmonize and improve the legislation involving the consumption and advertising of alcoholic beverages in the country.

On July 31, 2003, the president of Brazil signed Law No. 10.708. This law, known as the "Back to Home Act," represented a major step in the history of the Brazilian psychiatric reform, and pushed ahead the de-institutionalization of patients who had been committed to psychiatric asylums for long periods of time, by granting them regular financial benefits and referring them to outpatient mental health programs.

Since 1992 seven states and the Federal District have enacted legislation inspired on the bill presented by congressman Paulo Delgado. The states are Ceará, Espírito Santo, Minas Gerais, Paraná, Pernambuco, Rio Grande do Norte and Rio Grande do Sul. All such legislation provides for the substitution of treatment in psychiatric hospitals with other types of services. There are incentives for setting up public day hospitals and outpatient clinics (Psychosocial Attention Centers, generally referred to as CAPS), the occupation of beds in general hospitals, notice to the government in cases of involuntary hospital admission, and the definition of the rights of persons with mental disorders.

Today there are more than 1000 CAPS established and functioning in the country under the provisions of Health Ministry Ruling No. 336, of February 19, 2002.

The Health Ministry has issued a number of other rulings, the most important of which is, without a shadow of doubt, Interministerial Ruling No. 628, of April 2, 2002, which provided the National Health Plan for the Prison System. It calls for the inclusion of prisoners into the Federal Health System (SUS), including for the area of mental

health. This unprecedented initiative not only determines the existence of health care in prisons; it also opens a door to the question of the criminally insane.

Ruling No. 1077, of August 24, 1999, could also be underscored. It provides for pharmaceutical treatment as part of psychiatric care and assures basic mental-health medications for patients of outpatient health clinics that provide care for mental patients. This represents effective and regular financial resources to allow states and municipalities to maintain basic pharmacy programs in mental health.

Other rulings are aimed at refining the Brazilian Psychiatric Reform by setting up and regulating financial backing for home care services and determines evaluation by the Health Ministry of the mental health treatment provided by these and other federal services by establishing mechanisms for on-going supervision of inpatient and outpatient services. They also propose technical norms and alternatives to reinforce the continuation of the process of inverting the model of mental health treatment in effect in the country. A number of different actions are defined in this regard, including the following. 1) This legislation defines the minimal team of specialized outpatient services in mental health assigned to work in the treatment and supervision of home care services; 2) institutes a systematic annual process for evaluating and supervising both specialized psychiatric hospitals and general hospitals having psychiatric wards or beds; and 3) establishes criteria for classifying establishments by size and for complying with the criteria for evaluating the quality required by the Mental Health Sector of the Health Ministry regarding therapeutic processes. The National Sanitary Surveillance Agency must analyze the area of sanitary surveillance and determine classifications based on the size of hospitals and the quality of the services rendered.

In short, it can be seen that there was intense political and normative activity in this area between 1990 and 2003, during which time the psychiatric reform was implemented.

One year earlier, in 1989 a decisive experience in the city of Santos was begun under the leadership of the psychiatrist David Capistrano Filho. In late 1989 the first bill was introduced in the Federal Congress that, 12 years later, resulted in the Brazilian Psychiatric Reform Act.

Through a complex and systematic public policy established by state and municipal laws, and ministerial rulings, the Brazilian Psychiatric Reform called for sweeping changes in the treatment rendered to users in a number of ways. 1) It redirected the model for psychiatric treatment to include special treatment for patients who have been hospitalized for many years; 2) provided for punishment for involuntary or unnecessary hospital admissions; 3) encouraged the de-institutionalization of patients who had been committed to psychiatric hospitals for long periods by granting them individual financial aid to sustain their psychosocial rehabilitation and their inclusion in outpatient programs; 4) called for mental health treatment for incarcerated citizens, including the development of new modes of treatment for inmates with mental health problems; 5) provided for pharmaceutical treatment as part of psychiatric care;

and 6) assured basic mental health medication to be prescribed at outpatient centers that provide mental health care.

In other words, the reform establishes the material and organizational bases for new therapeutic practices aimed at including persons with mental disorders into society and culture. The psychiatric reform is an undisputed step ahead for the treatment provided in mental health as it released countless chronic patients from hospitals and asylums who showed no symptoms of insanity but who were simply poor, without families and without schooling. The persons in this category were clearly the victims of prejudice and, living as beggars in the cities, had been removed from urban spaces and taken to such asylums. This category, which today is known as "the homeless," or "street dwellers," are unable to adapt to opulent society and call attention to its limitations. How should society guarantee citizenship rights to this social group?

A very serious problem comes up here that drastically limits the extent of the psychiatric reform: what is the best method to guarantee the psychic inclusion of persons who show intense and resistant symptoms of isolation, who suffer from persistent delusions, who refuse reality, and show other manifestations that hamper or block their social inclusion?

The reform does not deal with this issue and implies that the great majority of hospitalized patients wish to be integrated into society and are ready for this step. But studies carried out in conjunction with the Laboratory of Fundamental Psychopathology at the Catholic University of São Paulo and with the University Association for Research in Fundamental Psychopathology show that this is not the case.

Many of those who have lived for years in mental hospitals have lost all contact with their families, friends and other persons. Others have mental disorders that prevent inclusion or at least make it very difficult. Many do not want to leave the hospitals or are even unable to do so, as they would risk even their lives if simply left on city streets. Others clearly say they prefer to live as beggars, and others yet are transvestites who work as prostitutes in situations of great poverty. Many prefer to have only tenuous contact with mental health workers and are not interested in any type of psychotherapeutic treatment.

In other words, the reform was carried out without taking into consideration the enormous complexity of the population who make use of mental health services and fails to deal with methodological and other substantial issues involved in psychotherapeutic treatment.

The use of psychotropic molecules represented an enormous step ahead in terms of social inclusion because it stabilizes many of the acute manifestations of mental disorders and greatly facilitates social relationships. But providing stability through medication does not mean that the patients involved are able to significantly improve their mental health. On the contrary, prolonged treatment with psychotropic substances causes addiction and intoxication, and results in very limited possibilities for

these patients. And any interruption in this type of treatment is almost always accompanied by a relapse of the symptoms the medication had controlled until that point.

In other words, the psychiatric reform failed to address the question of psychotherapeutic treatment for mental disorders. In fact, it dealt with such disorders as merely social phenomenon, a position that is based on Marxist theory. The laws and ministerial rulings that have been issued are not aimed at defining specific forms of treatment. They are rather characterized by the clear objective of including the mentally ill into democratic society as citizens and providing them with the necessary financial and institutional resources, including outpatient care at psychosocial attention centers, care homes, etc. But it does not say, or even suggest, how mental disorders should be treated, and this is the main obstacle to inclusion.

Differential diagnosis based on anamnesis or, more often, on the application of one of the classification systems, is not sufficient to alter patient's behavior. It is common knowledge that medication is often excessive and serves merely to hold down the most acute manifestations of symptoms that are undesirable and are the target of social prejudice. Society easily recognizes persons who are heavily medicated and refuses them opportunities for inclusion. These patients thus become one more marginal social category.

Patients with serious conduct disorders establish noticeable repetitious and standardized social relationships. These persons are unable to set up families, or even be part of families, hold down jobs or participate in associations, to cite just a few examples.

The success of the reform therefore depends on types of clinical practice and adequate treatment that is able to effect changes in the conduct of patients without the aid of excessive medication. The reform was organized under the presumption that mental health workers are prepared to perform specifically psychotherapeutic practices. But there is a considerable distance between the law and its corresponding practices, a fact that does not always show up in the official reports that are periodically submitted to the Health Ministry.

It is also easy to note that university education in Brazil has not yet adapted to this public policy, and there is thus a wide gap between university courses and the needs of concrete practice.

Finally, the university system tends to provide a general and abstract education that is fertile in contents but that largely ignores the specific aspects of the psychiatric reform and the work that is being carried out in this area.

But these difficulties are not insurmountable, and many mental health workers have developed clinical practices that have produced surprising results in their everyday activities. Thus, new activities and clinical practices have been "invented" by these

professionals, but are not always accompanied by methodological and psychopathological elaboration. The psychiatric reform opened the door to experiences and practices that were previously unheard of in psychopathology and in the clinical method. But, given the eminently practical nature of the work carried out in mental health, these experiences run the risk of being limited to the specific sphere of their day-by-day activities, thus simply creating a subculture in Brazilian society. If this were to happen, it would mean the total failure of the reform. The reform's main objective was to integrate the entire psychiatric system, and not just its users, into democratic Brazilian society and was meant to be characterized by open biological, mental and social exchange. It must not be forgotten that this type of integration is eminently political. In other words, it takes place in the *polis*, where power is exercised. Theoretically, power belongs to all, but persons with mental difficulties often exercise the power to have no power. They thus live out an existence that is completely destitute of power and they apparently believe that this is the only way to dominate the other.

The Brazilian psychiatric reform consequently needs to set up provisions so that these activities can become true experiences. In other words, knowledge must be socially shared in order to develop the possibility for research in mental health.

For this to happen, the eminently practical activities of workers in mental health must be systematized and written about. In this way, archives can be set up as fundamental components of the memory of the practices developed in the wake of the reform. In other words, mental health workers should become authors, and this implies transforming activities into experiences, through written narratives, that is, by sharing their wide variety of modalities of treatment. The path taken by these practices in treatment constitutes the clinical method, which must become known by writing and publication. An esoteric clinical method known only to those who practice it is of little use to the mental health establishment. Experiences must be described and disseminated among those who participate in the psychiatric reform.

This dissemination requires an appropriate and complex apparatus. Just as new clinical mechanisms and practices are needed, another type of apparatus must also be developed that will foster the production of narratives of clinical experiences. The creation of archives and the dissemination of the narratives are indispensable if workers are to become authors of the reform itself and if society is to become aware of what is happening in this sphere. And it is only in this way that a clinical method can become known and elaborated on for the objectives called for by the psychiatric reform.

The point is to create a narrative field that will constitute a new psychopathology by disseminating promising perspectives for clinical work aimed at including mental patients into society. Under these circumstances, it can be expected that attention will be diverted from the routine systems of classification of the forms of mental disorders, toward the undoubtedly broader and more gratifying task of attaining a better understanding of the essence and internal connections of psychopathological processes. One must be aware not only of the bewildering multiplicity of mental disorders in their external manifestations. We must also be able to understand them on

the basis of certain pre-suppositions by discovering the laws that govern their appearance and dynamics.

This complex and unending task will be based on facts observed in clinical practice, which, in turn, will provide the bases for a psychopathology understood as an emerging discourse that transforms clinical activities into experiences. In this way they can be become socially shared knowledge that can contribute to the construction of better methods of treatment.

If such a discourse takes into consideration the singularity and respective subjectivity that one sees in clinical practice, this psychopathology can very correctly be called fundamental psychopathology.

* I would like to thank Prof. Dr. Ana Cleide Guedes Moreira for her invaluable comments. Her attentive review of the text greatly helped make it clearer and more precise.

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