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Towards a Paradigmatic Shift in Mental Health Care?

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1. Introduction

Mental health care has its professional and theoretical foundation in-between medicine and the social sciences. Its history is marked by tensions between humanism, recovery orientation, client-centred approaches and “being with” as principles on the one hand, and custodialism, instrumentalism, manualized therapy, diagnostic cultures, medical care delivery and biogenetic understanding on the other. In recent years, spokesmen in the field have promoted a so-called integrated biopsychosocial model, saying there are some genetic dispositions, along with individual psychology and social factors that together predict the development of mental disabilities. In this chapter, the content of and evidence behind such an integrated model will be discussed, with reference to the possibility of combining such varied approaches as biogenetic and humanistic understandings, the status of genetic research, new findings when it comes to the causes behind mental suffering and the historical and recent consequences of a mental health care, in which the etiology and understanding of the phenomena have been limited and unsure. As we know, these methods have historically often had fatal consequences. But also today, the reports about degrading, humiliating and painful experiences are numerous. Reactions to this reality differ between strong efforts to improve existing services and campaigns to change attitudes and a contrasting fundamental criticism towards the laws that govern mental health care and the paradigm on which the laws are built.

2. An integrated biopsychosocial model?

Several researchers operate with two main approaches in psychiatry or mental health care, e.g. medical or contextual understandings (Wampold, 2001), or psychosocial or biogenetic explanations (Walker & Read, 2002). These approaches do not represent distinct, exclusive perspectives, but instead they borrow from each other. Nevertheless, it is still possible to distinguish between views based on a fundamental belief which say that mental suffering should be understood and treated as relational/psychosocial problems, the results of trauma, anxiety or existential suffering related to loneliness and the loss of meaning on the one hand, and beliefs which say that we are approaching the discovery of a biogenetic foundation for illnesses with emotional or behavioural expressions on the other. Until now, the conclusions have been unsure. Researchers talk about “genetic predispositions” and an interaction between “genes and environment” (Andreassen, 2005; Caspi et al., 2003; Surtees

et al., 2007; Nesvåg, 2008), but cannot document the existence of biological or genetic markers.

Recently, the field of epigenetics has shed some new light on the antagonism between the biogenetic and humanistic-contextual approaches, as epigenetic studies have revealed that conditions outside the gene can change its genetic expression (Fosse, 2009; Getz et al., 2011). With both animals and human beings, relational stress and assaults seem to influence behaviour and brain development by changing epigenetic control mechanisms, which can be interpreted as support for a stronger relational and contextual orientation.

Philosophers have pointed to the search for meaning as being genuinely imbedded in human nature (Bachtin, 1997; Vetlesen & Nordtvedt, 1994; Wifstad 1997). For example, within a bio-genetic perspective, medicalization may gain priority at the cost of helping to focus on existential dilemmas and search for meaning. As emphasized by Stenfeldt-Foss (1997), "The uncritical use of neuroleptic drugs and minor tranquilizers, instead of proper psychosocial and psychotherapeutic procedures, is an increasing danger in services for weaker groups lacking professional resources, thus threatening the patient-doctor relationship" (Medical Ethics and Medical Conduct, 1997, p. 14).

As Bentall (2003) points out, it is logically possible to both believe in genetic causes and be human, but at the same time, it is the heritage from Kraepelin, with his hypothesis about clearly distinguishable groups of illnesses with their respective biogenetic reference points, which made possible several of the cruelties found in the history of psychiatry. The biogenetic reference points legitimated a strong division between "us" and "them".

Still, we have yet to find a tenable rationale behind this division between "us" and "them". The question about what constitutes serious mental illness has no simple answer, while shifting trends also govern how diagnoses are developed and described. In 2011, two former editors of DSM (III & IV), Robert Spitzer and Allan Frances, warned against a development in which psychiatric diagnoses fit almost everybody, and young people can be recruited into the psychiatric system based on indicators that pathologize "normal" adolescent reactions (Angell, 2011). They referred to the National Institute of Mental Health in the US, which says that one-fourth of all Americans receive one psychiatric diagnosis every year. At the age of 32, 50% have suffered from some type of anxiety syndrome and 40% from depression. The former editors ask: Which numbers will we then see when these people get to the ages of 50, 65 or 80? This increase in diagnoses is seemingly at odds with findings from the comprehensive, longitudinal WHO's multi-centre study (see among others Hopper et al., 2007). The study started in 1966 as a large-scale, cross-cultural study conducted simultaneously in Columbia, Czechoslovakia, Denmark, India, Nigeria, China, the Soviet Union, Great Britain and the US. Summing up after 25 years, the authors could state that people with schizophrenia recover in spite of the methodological challenges. Globally, 60% had recovered when the study was finished. A striking finding was that the rate of recovery largely varied between industrialized and developing countries, though in favour of the latter. The recovery rate in developing countries approached 70%, whereas it was only 20% in the industrialized countries. Because of these findings, it becomes urgent to understand mental illnesses in contexts, not only for professional and scientific reasons, but also ethical ones. Since the neuro concepts have become metaphors for what is human and what happens in our consciousness, we have some special ethical challenges (Kollek, 2004). When psychological and cognitive phenomena are explained as causal effects of brain chemistry,

human dignity, liberty and autonomy are affected. Metaphors can help facilitate communication, but may also carry with them some potentially dangerous conceptual baggage. Explaining biology (for example, somatic disease) with biology is unproblematic, but to explain consciousness with biology may have consequences for social interaction and stigma. As one example, it may now seem more opportune and legitimate to talk about bad genes than bad parents (Joseph, 2004), which has comprehensive consequences for stigma, as a biogenetic etiology has been shown to increase stigma, while a psychosocial etiology reduces it (Walker & Read, 2002).

What is often called a biopsychosocial model may in practice resemble a primarily biological model. The implementation of psychosocial therapeutic models easily lose terrain related to more instrumental means. The paradox in this field lies in the lack of evidence of an etiology which could legitimate those instrumental means. The Office of the United Nations High Commissioner for Human Rights says that: "The medical and charity model is completely abandoned in favor of a human rights and social model" (OHCHR, 2007). As a result of this, mental disabilities should be met with good relations, dialogues and the satisfaction of universal human, material and psychosocial needs.

3. Definitions of otherness

To make a division between "us" and "them" seems to be a phenomenon deeply imbedded in our culture. As we will also see, this division is sustained in several ways. Definitions of otherness are often based on special individual- and group properties, but also exist without such distinguishing properties. Medical, juridical, sociological and philosophical perspectives can be helpful in order to understand the reasons behind the definitions of otherness, in this case related to persons with mental disabilities.

As previously mentioned, there has been a long-lasting belief that mental illnesses can be explained by some organic failure/damage. As early as the 19th century, psychiatrists campaigned for adding some kind of hard science to the humanistic orientation in moral treatment institutions and to define mental illnesses as neurological, located in the brain (Withaker, 2004). But still, in 2011 no biological markers can tell when mental health has changed into mental illness. In spite of this weak ability to distinguish different psychiatric diagnoses from each other and tell when illnesses arise, new diagnoses have been developed for the next DSM version, and new groups will be included in existing diagnoses. Diagnoses are also closely associated with medication, with 500,000 children in the US now taking some type of anti-psychotic medicines (Angell, 2011), which must necessarily be based on some biological/genetic explanations. Ideas about biological changes and inherited vulnerability still exist and contribute to the justification of special approaches to persons diagnosed with serious mental illnesses, as will be elaborated on in the next paragraph.

According to Norwegian legislation, serious mental illness is a basic condition for involuntary confinement and treatment, and an additional condition is that the treatment is needed for health reasons, *or* that the person represents a danger to his/her own or other persons' lives or physical health (Norwegian Mental Health Act 1999, § 3-3- and 4-4). These paragraphs invite judicial assessment, as there are large variations in both involuntary confinement and treatment among different geographical regions in Norway. Some regions have 10 times as much forced treatment than others in relation to the population (Bremnes

et al. 2008a+b), which in a clear way illustrates the arbitrariness in coercive treatment and the effects of a law that says: Forced treatment may be effectuated when it is obviously no use in attempting voluntary treatment, when benefits from the treatment clearly outweigh the disadvantages, and when the treatment is in accordance with acknowledged professional psychiatric methods and justified clinical practice (Norwegian Mental Health Act §3-3,1 and §4-4,1).

As early as 1994, the European Council expressed concerns over the high number of complaints related to bad treatment, which were just within the limits of mistreatment, such as over-medication and the devaluation of the client's needs (Council of Europe, 1994). The available knowledge about alternative approaches and treatments is highly relevant when it comes to a client's legal status. The European Convention on Human Rights states that the "least encroaching treatment" should always be used (Palm & Ericsson, 2005; Bartlett et al., 2007; Thune, 2008).

Knowledge about non-infringing or less infringing treatments has existed for a long time, for example with the Soteria House model, with the "being with" principle as opposed to long-term medication (Soerensen, 1982; Bola & Mosher, 2003; Bola et al., 2006). But as long as concepts about otherness, as expressed in the concept of "serious mental illness", exist in the law and imply a comprehensive professional power (the right to receive treatment based on a free and informed consent can be set aside), it has been difficult to protect mental health clients against degrading and infringing treatment, though now there are signs of a change to come. The disproportion between the arbitrariness in labelling people as seriously mentally ill on the one hand, and the huge consequences such diagnoses cause on the other has become more visible, not least with the United Nations (UN) and survivors organizations around the world having made a common effort to abolish discriminatory settlements for *all* disabled people (mental disabilities included), which has resulted in the Convention on the Rights of Peoples with Disabilities (CRPD). The convention legally took effect in 2008, and is an important step towards the abolition of forced institutionalization and treatment on the basis of disability. Its purpose is to "protect and ensure the full and equal enjoyment of all human rights and fundamental freedom by all persons with disabilities, and to promote respect for their inherent dignity" (Art. 1). The convention further states that "persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments" and that "persons with disabilities enjoy equal capacity on an equal basis with others in all aspects of life" (Art. 12). If they require support in order to exercise their legal capacity, this shall be provided. Regarding health care, this shall be of the same quality for persons with disabilities as it is for others, "including on the basis of free and informed consent" (Art. 25). The convention is a sign of changes in a more humanistic direction, which will be further elaborated on later in the chapter. The European Court of Human Rights may take the lead in the process towards a more humanistic direction and affirm that serious infringements are not redefined as necessary treatment.

Concepts about "otherness" related to mental health clients, in medical as well as legal contexts, are changing. Definitions of otherness are culturally bound, which may indicate that societies need a division between "us" and "them" for the sake of social integration, at least that is what social scientists say. With reference to Foucault (1973), Thomas Scheff (1999) describes how societies need excluded and stigmatized groups in order to secure the identity of the people inside the society. One example of this is how the big institutions in

France were filled with new groups in the 17th century as leprosy disappeared. Scheff's analysis is important in order to understand social mechanisms on the macro level, thereby creating change. His deviation theories should not be seen as fatalistic statements, saying that there must always be excluded groups. Maybe there will, but with the help of ethics theory, other perspectives can also be outlined. The philosopher Emanuele Levinas (1993) challenged our concepts about otherness by saying that there will always be people we cannot understand, and that we should accept that we cannot fully understand another human being. Instead of defining and categorizing (and deciding whether people belong "inside" or "outside"), we should accept that it is not about understanding and control, but about love, respect and feeling responsible. We may not be able to avoid notions about otherness, but it should be possible to counteract social exclusion of groups based on their disabilities.

4. Degrading and painful experiences

Even if the history of psychiatry for the most part is seen from a professional perspective, patients have also told and published their stories. Larsen and Andersen (2011) have studied psychiatric patients' autobiographies from 1918 to 2008, and some of them talk about "a holy duty" when they explain their reasons for writing down and publishing their experiences from psychiatric care; they want to inform the community about conditions in the treatment system that ought to be changed. In 1925, one of the authors wrote from his heart that he wanted to prevent others from experiencing the same horrors and monstrosities he himself had endured. In the last period studied by Larsen and Andersen (1980-2008), there had been comprehensive reforms in the mental health service systems, as user involvement had become a central objective. Even so, no fundamental changes seem to have taken place from the patients' points of view, although it is possible that patients' experiences are not seen as being valid sources of knowledge. It could also be that patients' experiences indicate that more fundamental changes in understanding and basic values are needed, as Larsen and Andersen ask. Ekeland (2011) has elaborated on this point of view, and says that the darker sides of the history of psychiatry can be understood as a result of an epistemological mistake; instead of acknowledging human beings' subjectivity, objectification has taken place. This occurs when phenomena are created, communicated and interpreted by human beings (subject ontological phenomena) and treated as phenomena that exist independent of human beings. The phenomena studied in psychiatry and mental health care can hardly be counted as object ontological. In this field, we have to relate to cultural products and experiences picked up during dialogical processes such as emotions, behaviour, expectancies, hope, trust, etc. The phenomena should be acknowledged as human, individual and context-dependant. In order for health policy to take a more recovery-oriented and user-involved stance, a new foundation for research is needed that is based on the insight that interpretations and normative evaluations determine what we see and find. In this field, we cannot catch the ontology independently of those interpretations and evaluations.

When human subjectivity is wrongly exposed to objectification, ethical values are also at risk: When the suffering person and his/her relation with him/herself or the world is studied by an objectifying look, there is danger afoot because we all need to support the Other as a subject in order to protect ourselves against our own inhuman tendencies (Ekeland, 2011).

For more than 150 years, psychiatric and mental health care has been mainly based on a medical epistemology in which human beings are exposed to the medical glance, searching for medical symptoms rather than human, individual, context-related and interpreted phenomena. This is also mirrored in narratives about users' experiences from psychiatric and mental health care over the latest 10 years (Kogstad, 2009), from which I will give some examples.

The data was collected in cooperation with the national user organization in Norway, Mental Health Norway (MHN), which was chosen because it is the largest user organization in Norway. The organization has a good relationship with the government, as well as a well-developed administrative system that was able to facilitate the collection of data. During the period of data collection, there were approximately 5,000 members throughout the entire country, and about 4,000 of them were chosen randomly and invited to take part in the study, with a response rate of nearly 20%. Out of these, 492 (151 men and 341 women, aged 19–90 years) also answered one or both of the open questions at the end of the questionnaire. These respondents have experience from all parts of the mental health care system, including traditional psychiatric institutions, outpatient clinics, day centres and individual therapy. Sixty-seven percent received a disability pension, 13% had a job and 20% a combined disability pension with a job or studies.

The material presented here consists of stories written in response to the question: If you have had a strong negative experience, would you like to describe such an event?

Although several informants said it was too difficult to write about negative and humiliating experiences, 335 nevertheless wrote about such episodes. A statistical representation related to user organization, or mental health clients in general, cannot be claimed, though distribution by gender, age, disability pension, education, job, in addition to the fact that the informants have experience from all parts of the health care system, suggests that the experiences and chosen categories are applicable across many user categories. The narratives vary in length from one line to several pages, and the longer stories often give in-depth information concerning background, causes, experiences, feelings and concrete elements in the recovery process or the traumatic experience, although quite brief reports also sometime contain important information such as: "Strong, painful effects of Trilafon." Out of the 335 negative stories, 267 were seen as being informative enough to be included in the analysis. The material is still rich and, most importantly, it is written by people who have first-hand knowledge of the experiences they describe.

The 267 stories about negative experiences were divided into three main categories: Experienced miscommunication, rejection and humiliation, with some of the narratives from the categories of rejection and humiliation shown below.

Subcategories under "rejection" were: "no treatment in institution apart from medicinal treatment", "no access to treatment or institution/no follow-up after discharge", "negative experiences at state welfare institutions", "social dilemma and religious needs rejected", "confidence lost because of deception", "childhood traumas and war experiences rejected" and "children/family not cared about when person is committed". All subcategories are illustrated in the stories:

I was forcibly sent to the hospital because I said I felt like committing suicide. I was heavily medicated and had only one talk with the doctor during my entire stay. I felt I was left totally on my own,

together with other patients who screamed and smashed furniture. I shared a room with people who scared me. It was a painful experience. (woman, age 45)

I attempted suicide in the early 1980s. I was taken to the hospital by ambulance, my stomach was pumped and then I was sent home by taxi, dirty and wearing only my pants. I worried a lot about meeting my mother and my employer. I had no one to talk to after this incident. (man, age 57)

My GP would not accommodate my wishes when I asked for sick leave. The result was that I lost my job and just wanted to commit suicide. (woman, age 55)

I got the clear feeling that the psychiatric ward did what they could to help me when I was an inpatient. But when problems that had been brewing underneath came to the surface and childhood traumas emerged, I was once again alone with no help available. (man, age 50)

Once when I was in my thirties, I was in the hospital. The anxiety came back and I asked if I could talk to a psychiatrist. I thought that at last I would be able to open up and talk about the incest I had experienced as a child. His answer was: It was such a long time ago and should just be forgotten. (woman, age 53)

I was committed and had to leave my children, aged 2–19 years. No help was offered. I was neither listened to nor taken seriously, and did not get any help from the community health services. I was just given medicines with painful side effects. (woman, age 60)

Subcategories under “humiliation” were: “accused and made a fool of”, “negative experiences with medication”, “commitment”, “forced medication”, “punishment”, “forced removal of medicines”, “incorrect diagnoses” and “forced sterilization”:

I was filled with anxiety the whole night when I was put in a room on my own with a night duty employee who didn't talk to me, but threatened to give me an injection if I didn't calm down. (woman, age 44)

I was not believed when I told them I had an adverse reaction to that special medicine. I had convulsions for a long period before I was given the proper antidote. (woman, age 45)

After less than half an hour, this strange doctor concluded that I should be sent to the hospital. I objected and said: “It will not help.” But a person in my situation suddenly has no right to express herself. The doctor said: “Then it is a compulsory admission!” I objected and objected, but my voice did not count any longer. My husband signed the paper (after the doctor threatened that if he didn't, the police would do so). I don't think I have ever felt so deceived before. I was angry, sad and empty (...), and overwhelmed by the feeling of being totally turned down. I had lost everything. It felt like mental rape. This happened four to five years ago, though I can still feel it all today. The emotions have become embedded inside me and will always remain with me. (woman, age 38)

I was medicated by depot injection, but the way they did it was wrong. I didn't want the medicine. Four-five people were in the room. One gave the injection, while the others held me. I resisted. I was afraid. After this, they all left. I was alone. Later, I didn't want contact with the staff at all. I hid under the bedspread. Medication was the only physical contact I experienced during the stay. I think I needed the medicines. That was not the problem. After having been medicated several times, one person sat down at the bedside. This was a help of course, but all my bad feelings were still there. (woman, age 32)

I was confined and did not want to get out of bed. I was punished with no more cigarettes. They took away all I had and locked me into a room for three days. That weekend it was my birthday. (man, age 37)

Several times they have given or taken away medicines without telling me what was going on. (man, age 37)

I was given a wrong diagnosis. I wasn't believed when I told about my problem and was "stored away" in a nursing home in the countryside. The doctor told me that I would never recover and that this would be my home forever. But I met one person who understood that something was wrong. She was unskilled at that time, but she listened to me, encouraged and supported me, and helped me get away from that place. Today I have been taken off the sick list; I no longer take any medicines, live in my own house, work as a volunteer and study at the university. (woman, age 64)

It is difficult to talk about what I have experienced. When my third child was born, my husband was a psychiatric patient and sterilization was forced on me. The child died after five weeks. I didn't get help, but I became ill because of the bereavement and was sent to the hospital. The hospital contributed to furthering my mental problems. I have struggled a lot with this, and feel that the system does not believe in me. (woman, age 67)

Even if these stories represent only a small part of the narratives pertaining to humiliating experiences that infringe on clients' rights, the documentation is dramatic. The informants talk about situations in which the service system contributes further harm and trauma to the clients. Many stories are marked by an instrumental attitude to the service users and describe actions that can hardly be understood if they are not motivated by outdated views and the stigmatization of mental health clients, who tell about how their voices, feelings and opinions are of minor importance. Some of the episodes happened years ago, while others are quite new. But even if some experiences may belong to the past, the "victims" still fight with the aftermath of stigmatizing attitudes. Lawyers have underscored that encroachment in a person's private life demands treatment and recovery programmes of the highest quality (Syse & Nilstun, 1997). As long as this quality does not exist, then the right to intervene dramatically into people's lives must be questioned. Commitment and forced medication are often described by clients as being an extreme and often disabling experience. When we read clients' stories, we also get the impression that such actions are directed towards the stereotype of a mentally ill person and not at one who tells a detailed, thoughtful and emotional story. Several studies carried out in recent years show that there is little difference between the attitudes of the general public and psychiatrists towards people with mental health problems (Lauber et al., 2006). The studies even indicate that psychiatrists have more of a negative stereotypical view than the general public or other mental health professionals. The lack of responsiveness to clients' voices emerges as a major problem, thus causing reasons for concern regarding the protection of human rights for mental health clients.

5. Humanistic and contextual approaches

A humanistic perspective has both an ethical and scientific basis. Human beings live in a dimension of meaning that can primarily be experienced through dialogic relations. Dialogic relations are also fundamental for our existence and for a feeling of control and dignity, and because dialogic relations are fundamental, they cannot be rejected (Bachtin, 1997; Kirmayer, 1993; Sampson, 1993; Vetlesen & Nordtvedt, 1994; Wifstad, 1997). A humanistic perspective involves understanding emotional pain within both an existential and contextual perspective, a perspective in which the picture of human experiences and relations are sustained in its social complexity, without being reduced to biological or intra-

psychic mechanisms. Still, with a contextual perspective, one cannot claim a meta-perspective. Whatever the position, efforts are needed to get into a dialogue with other positions, e.g. positions which are closer to the clinical field, with its more practical orientation and often acute problems that must be solved immediately. Of special interest here is how the positions of service users can be made more visible. Can researchers help? Maybe not, if we operate with absolute divisions between positions and only acknowledge knowledge obtained by personal experiences, although by such divisions, neither the users nor the professional's position makes sense. No single person can cover the experiences of an entire group, as some ability to generalize from one's own experiences must be taken for granted. We all have some kind of user experiences and a genuine, humanistic engagement can also help in understanding users' experiences. At the same time, it is important to bear in mind that some experiences are so traumatic that it is difficult or impossible to believe in dialogue and constructive solutions.

For ages, philosophers have discussed human beings' abilities to handle existential fragility, loss and anxiety. Being a human being means to be exposed to uncontrollable and unforeseen events which necessarily disturb our souls and make anxiety an existential modus (Yalom, 1980; Nussbaum, 1994; Hall, 2000). Platonic and Aristotelian philosophers had different solutions to these dilemmas. Platonic philosophers recommended transcendence and withdrawal, while the Aristotelians emphasized that love and relations is what give meaning and happiness and that the challenge is "a robust embrace of the human" (Hall, 2000:179) which included love and close relations, as well as the natural anxiety about death and separation. After having reflected upon fundamental, universal existential questions, Martha Nussbaum points to the ability to reflect over these questions as therapy for anxiety and fragility that is naturally embedded in our human existence. With this reflection, she says that the fundamental choice between rejection or the embracing of our living conditions becomes clearer.

Rollo May (1971) was one of the founders of humanistic psychology, and also focused on the ability to make fundamental choices based on a person's own values. Humanistic psychology has its roots in existentialism and Rollo May stressed that human conditions such as loneliness and a feeling of lost meaning could only be handled if the person discovered his/her own values and became responsible for his/her own choices.

Based on this way of thinking about emotional suffering, Hummelvoll (1997) has outlined the following principles for meetings with persons in crisis situations: Equality, mutuality, presence and acceptance, so that the person's self respect is strengthened and his/her own solutions acknowledged, support in making responsible choices and in the search for meaning, coherence and hope, an openness in dealing with moral conflicts and feelings of guilt, and help in the process of gaining independence, freedom, honesty and a life based on one's own values. These principles can also be seen as therapeutic guidelines.

6. A real biopsychosocial model

Through comprehensive review studies, Read et al. (2008) have provided a considerable contribution to the understanding of contextual factors, as well as illustrating that what is often seen as a genetically inherited vulnerability to stress can be acquired via adverse life events. As stated earlier by Zubin and Spring (1977), vulnerability can be acquired by

trauma experiences, specific diseases, perinatal complications, family experiences, adolescent peer interactions and other life events, although their description of a biopsychosocial model was either misunderstood or misused. According to Read et al. (2008), asking about one's childhood and trying to understand the contextual meaning of symptoms has been outweighed by an approach that merely counts symptoms, gives the person a diagnosis and medication. This trend is clearly mirrored in research in which the focus on biological causes is on the rise. Out of 1,284 publications about childhood schizophrenia between 2000 and 2008, only five were related to child abuse and eight to poverty. The authors document how crucial factors such as child abuse and poverty really are, while revealing that poverty is even more strongly related to schizophrenia and psychosis than to other disorders. Based on the weighted average in 59 studies, the authors found that 64.5% of the women and 55% of the men had been subjected to either child sexual abuse or child physical abuse, with the combined rate at 60.02%. But estimating the prevalence of childhood maltreatment by using only child sexual or physical abuse as indicators leads to underestimation, as studies among first-episode schizophrenia spectrum inpatients also found that childhood emotional abuse mounted to 94 %, childhood emotional neglect to 89% and childhood physical neglect to 89%. Furthermore, studies of psychosis and schizophrenia have consistently found high rates of affectionless control parenting. There is also a pattern emerging in which the strongest relationships with abuse and neglect appear to be for hallucinations and the relationship between child abuse and hallucinations also exists across diagnostic boundaries.

In 2005, a review based on four population studies and a myriad of other studies (Read et al., 2005) concluded that child abuse is a causal factor for psychosis and schizophrenia. In the media, the research was presented as something that could cause the psychiatric establishment to "experience an earthquake that will shake its intellectual foundations" (James, 2005).

Since the 2005 review, seven more population-based studies have been published. The 2008 review (Read et al., 2008) then built on 11 population-based studies by seven independent research teams, using nine different samples drawn from six countries. In all of the studies, higher levels of child maltreatment or neglect were found in the psychosis groups.

The probability of a causal effect between child maltreatment or neglect and psychosis is increased if we find that the first not only predicts the second, but that more of the first – greater severity or frequency of abuse – is more related to the second, i.e. that there is a dose-response. The eight studies that investigated this dose-response hypothesis confirmed the hypothesis. According to the authors, it seems that the hypothesis that there is a specific genetic disposition for schizophrenia is turning out to be one of the costliest blind alleys in the history of medical research. This statement is supported by other researchers, e.g. example Hamilton (2008), who by then had conducted the most comprehensive genetic association study of genes. Hamilton wrote that "none of the polymorphisms were associated with the schizophrenia phenotype at a reasonable threshold for statistical significance" (Hamilton, 2008, p. 420) and that "The distribution of test statistics suggests nothing outside of what would be expected by chance" (Hamilton, 2008, p. 421). None of the researchers referred to by Read et al. (2008) argued that biological processes are irrelevant. There are biological processes underlying the mechanisms by which trauma leads to psychosis, and all mental processes have neurological and biochemical correlates, but even

if these correlates can be identified, we have not discovered a *cause*. Read et al. (2008) compare such an argument with assuming that because grief also causes reactions in the brain, it is the brain that causes the grief and sadness. In contrast to this, the Trauma Neurodevelopmental Model (TN) of psychosis says that changes in the brain such as overactivity of the HPA axis, dopamine, norepinephrine and serotonin abnormalities, ventricular enlargement, etc. happen because of the brain's reaction to the environment. Biological differences found in the brains of persons with psychosis are also found in the brains of abused children, which is a finding that supports the theory that a heightened sensitivity to stress as traced in the brain's stress regulation mechanisms can be caused by childhood trauma.

This documentation implies that psychosis can be prevented. If child abuse is a causal factor for psychosis to the same extent as with other psychological problems, the authors then argue that the same primary prevention programmes that work for other problems will also work for psychosis. It is about keeping children safe and supporting families.

Another gain from accepting this well documented theory is that persons with diagnoses that say they have schizophrenia or psychosis are not seen as being genuinely different from "us", which is essential when it comes to a discussion about human rights for persons under mental health care. An important question is whether their disabilities qualify for treatment according to a special law and exemptions from the European Convention on Human Rights - indicating reduced decision capacity - or should they enjoy the same rights and freedoms as other groups in society when they need assistance from the health service systems?

The UN Convention on the Rights of Persons with Disabilities (CRPD), which was signed in 2006, builds on a social model which says that disabilities are the result of an interaction between an individual and barriers in a society. Therefore, the convention also adopts a human rights and social model for disabilities, including mental disabilities, as underscored by the UN High Commissioner on Human Rights. This new model also means a new legal position for mental health clients. As we shall see in the next paragraph, the CRPD states that all health care must be based on a free and informed consent.

7. Signs of a paradigmatic shift

After the CRPD was signed, 20 countries soon ratified the convention so that it could also be ratified as an international convention. As of 2011, approximately 100 countries had ratified, thus allowing mental disabilities to be included on equal basis with other disabilities. The convention states that *"persons with disabilities enjoy equal capacity on an equal basis with others in all aspects of life"* (Art. 12). It further states that health care shall be of the same quality for persons with disabilities as it is for others, *"including on the basis of free and informed consent"* (Art. 25).

The CRPD takes the legal protection of mental health clients a step further in relation to the European Convention on Human Rights (ECHR) from 1950, in which exceptions could be made for mental health clients, depending on medical judgments. It seems as if the time is now ripe for the European Court to take a more independent attitude towards medical judgments in the mental health care system, which is supported by the CRPD.

As stated by the UN Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health (Report of the UN Special Rapporteur on the right of everyone.. 2005): *“The Mental Illness Principles recognize that no treatment shall be given without informed consent. This is consistent with fundamental tenets of international human rights law, such as the autonomy of the individual. But this core provision in the Principles is subject to extensive exceptions and qualifications. (...) in practice their combined effect tends to render the right of informed consent almost meaningless.”*

The CRPD was developed from the insight that the human rights of people with disabilities in many areas still have a weaker protection than the rights of other groups. The main objective of the convention is to prevent discrimination against people with disabilities, while also moving away from a model in which disabilities are seen as something individual - and people with disabilities as objects for medical and other interventions - to a model and practice in which all people have dignity and human rights on equal basis with other human beings. The CRPD substitutes the medical model with a social and human rights model (Orefellen, 2011). The Office of the United Nations High Commissioner for Human Rights (OHCHR) supports this point of view: *“First the Convention recognizes that disabilities are the result of interaction between an individual with impairment and the physical, attitudinal and other barriers in society. The medical and charity model is completely abandoned in favour of a human rights and social model”* (OHCHR, 2007).

The OHCHR also emphasizes the legal capacity of persons with disabilities: *“Article 12 of the Convention requires States parties to recognize persons with disabilities as individuals before the law, possessing legal capacity, including the capacity to act, on an equal basis with others”* (OHCHR, 2009), and further says: *“The Convention on the Rights of Persons with Disabilities (CRPD) states clearly that deprivation of liberty based on the existence of a disability is contrary to international human rights law, is intrinsically discriminatory, and is therefore unlawful. Such unlawfulness also extends to situations where additional grounds – such as the need for care, treatment and the safety of the person or the community – are used to justify deprivation of liberty.”*

Under international human rights law, persons with disabilities are entitled to enjoy their rights to liberty and security on an equal basis with others, and can be lawfully deprived of their liberty only for the reasons, and in accordance with the procedures, that are applicable to other persons in the same jurisdiction” (OHCHR, 2008a). This citation also implies that crime is crime irrespective of diagnoses and disabilities, and that the judicial system and the health care system should not be mixed. The point is made clear in the following paragraphs:

“(...)Where additional grounds such as dangerousness, (...) are put forward to justify the restriction of liberty of a person with a mental and intellectual disability, such a person shall be subjected to detention on such grounds only in as much and on the same grounds as any other person, with no reference to his or her mental or intellectual condition” (OHCHR, 2008b).

“Laws contemplating dangerousness as a ground for deprivation of liberty should be equally applied to all” (OHCHR, 2007).

Article 12 seems to not open up for a reduced legal capacity or exemptions in any case, whether serious disabilities or comprehensive needs for help. (Orefellen, 2011). Instead, the CRPD builds on a model in which persons with disabilities should be ensured of getting the needed support in order to make decisions: *“This year as we focus on the right to act, let us recognize all people's right to make their own choices, and take their own actions as they see fit.”*

Whenever people with disabilities need assistance they should be supported by people of their own free choice in making decisions, but never replaced in their legal capacity to act under no circumstance" (CRPD –committee, 2009c).

To ensure full inclusion and equal rights, it is necessary to tear down physical, judicial and other barriers that particularly affect people with disabilities, and to offer assistance in such a way that fundamental rights can be enjoyed on an equal basis with other groups. This implies a rethinking of both practice and legislation, which also demands comprehensive processes of increasing awareness (Orefellen, 2011).

The fundamental principles in the CRPD convention are dignity, autonomy, the freedom to make one's own choices, equality and non-discrimination, which also implies that institutionalization without a person's free and informed consent must be abolished:

"Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. This must include the repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness" (OHCHR, 2009).

Additionally, Article 17 of the CRPD, which is about the right to respect in relation to physical and mental integrity for all peoples, including persons with disabilities, seems to be important in regard to coercive treatment in psychiatric and mental health care. When the CRPD committee examined Tunisia in April of 2011, Article 17's "Protecting the integrity of persons" was included in the "List of issues", and Tunisia was asked to document legislation that protects persons with disabilities from medical experiments and treatment without their free and informed consent, as well as outlining arrangements which will ensure that persons are not exposed to mechanically coercive means and coercive treatment in mental health care (CRPD, 2010b; Orefellen, 2011).

Serious infringements that would normally be classified as mistreatment in mental health care could be redefined as "necessary" health care, which is seen as a problem under the new paradigm that the CRPD represents:

"Medical treatments of an intrusive and irreversible nature, when they (...) aim at correcting or alleviating a disability, may constitute torture and ill-treatment if enforced or administered without the free and informed consent of the person concerned."

"The administration in detention and psychiatric institutions of drugs, including neuroleptics that cause trembling, shivering and contractions and make the subject apathetic and dull his or her intelligence, has been recognized as a form of torture."

"The Special Rapporteur notes that forced and non-consensual administration of psychiatric drugs, and in particular of neuroleptics, for the treatment of a mental condition needs to be closely scrutinized. Depending on the circumstances of the case, the suffering inflicted and the effects upon the individual's health may constitute a form of torture or ill-treatment" (SRT, UN special Rapporteur on Torture, 2008).

The Human Rights Council (2009) has underscored that there are *no* exemptions from the articles that protect people against the deprivation of liberty:

"Prior to the entrance into force of the Convention, the existence of a mental disability represented a lawful ground for deprivation of liberty and detention under international human rights law. The Convention radically departs from this approach by forbidding deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory."

8. The possibility of change

According to Kuhn (1970), Paradigmatic shifts take place when scientific discipline is thrown into a crisis. There have been several discussions over both the concept paradigm and paradigm shifts. New theories and ideas should be very comprehensive in order to qualify for the term, paradigm shift. Kuhn wrote that paradigm shifts usually happen via revolution and that the language and theories of various paradigms are incommensurable, though of course it can be doubted as to whether languages or theories *can* be incommensurable with one another.

In relation to psychiatric and mental health care, it is difficult to estimate as to what degree fundamental changes will take place and if so, whether the changes qualify for a paradigm shift, i.e. if there really is a scientific revolution taking place. Arguments in favour of the position that fundamental changes will come are the long-lasting tensions between a medical and psychosocial discourse, the unsuccessful attempts at documenting the existence of genetic and biological markers, the dark side of history as represented by very negative and painful user experiences over the centuries, the humanistic and successful alternatives outlined, and not least, the international ratification of the Convention on the Rights of Peoples with Disabilities, which is based on an international consensus about the need for substituting the medical and charity model with a human rights and social model.

What we are also seeing now is an intellectual battle between the followers of the different "paradigms". It seems as if this will not result in any reconciliation between the two main approaches. Arguments and documentation in favour of an approach at odds with mainstream professional thinking are not easily integrated into existing models. The documentation can be registered, but neglected when it comes to policymaking, which is what seems to have occurred in the Norwegian, government-appointed group, whose mandate it was to give a report on legislation related to coercive treatment in mental health care (NOU, 2011:9); acknowledging the weak, and at the same time often harmful effects of psychotropic drugs, but still allowing forced medication.

That there may be sudden changes instead of a rational and controlled process based on evidence and scientific documentation is indicated by the former lead editor of DSM-IV, Allan Frances. Frances, who earlier did not want to be "a crusader of the world", said in an interview in 2010 that, "The idea of more kids getting unneeded antipsychotics that would make them gain 12 pounds in 12 weeks hit me in the gut. It was uniquely my job and my duty to protect them. If not me to correct it, who? I was stuck without an excuse to convince myself" (Interviewed by Gary Greenberg for Wired, December 27, 2010; published January 2011). Frances fears that by use of the proposed diagnostic category, "psychosis risk syndrome", as well as other newly constructed diagnoses, "DSM-5 will take psychiatry off a cliff".

There is no doubt that the mainstream thinking in psychiatric and mental health care is challenged from different sides and that changes will come, though in what way and how comprehensive are not easy to predict. Thus, we are facing exciting times.

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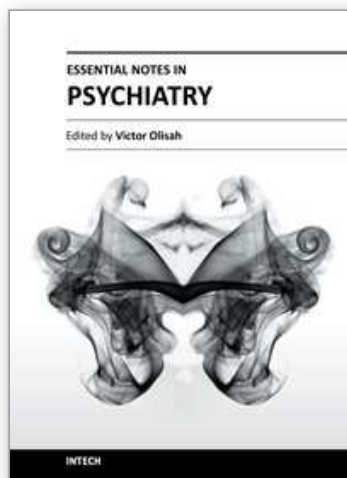
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