Working draft: do not openly circulate

Political Abuse of Psychiatry, Medical Torture, and Victim De-Legitimization: Insights from an International Symposium

Abstract: The political abuse of psychiatry is an ongoing, systemic phenomenon rooted in the replacement of sound governance and ethical medical standards by incompetent authority, rogue state practices, and criminal misuse. Drawing from a global symposium integrating survivor testimony, academic analysis, and human rights advocacy, the discussion highlights how mental health systems -when left vulnerable by corruption, inefficiency, or deliberate political manipulation- become instruments of repression rather than healing. The ease with which abuses occur in failed systems, the profound human and economic costs inflicted, and the perpetuation of systemic failure through the weaponization of psychiatry are analyzed in depth. Comprehensive solutions are proposed across international, national, institutional, community, and individual levels, emphasizing the urgent need for rights-based, trauma-informed, interdisciplinary reform. Restoring psychiatry's ethical foundations is presented not merely as professional necessity but as a profound moral imperative to protect life, freedom, sanity, and human dignity on a global scale.

Keywords: Political abuse of psychiatry; rogue states; failed healthcare systems; human rights violations; psychiatric coercion; trauma-informed care; mental health reform; international crime; dignity and autonomy; systemic failure; survivor advocacy; healthcare ethics.

Introduction

Throughout history and across the World, psychiatry has held the power to help -or to harm. It is a field that touches the most intimate aspects of human life: thought, emotion, behaviour, identity. Yet this same power has been used to silence, punish, and erase. Under the guise of care, individuals have been subjected to forced treatment, indefinite detention, and forms of medical coercion that violate basic rights. These are not merely past injustices or errors in judgment, but the result of structural conditions that allow systems of health to be bent into tools of control. When dissent, difference, or distress caused by the very same system and criminal actors are labeled as pathology, no one is safe from the risk of being made to suffer. This proceedings paper begins from that stark reality, but not to accept it. Rather, it aims to examine how these abuses occur, why they persist, and what can be done to transform psychiatry into a field worthy of its healing promise.

[Add: https://www.hrw.org/report/2018/09/10/eradicating-ideological-viruses/chinas-campaign-repression-against-xinjiangs , Faber, S. C., Khanna Roy, A., Michaels, T. I., & Williams, M. T. (2023). The weaponization of medicine: Early psychosis in the Black community and the need for racially informed mental healthcare. *Frontiers in psychiatry*, *14*, 1098292. and Metzl, J. M. (2010). *The protest psychosis: How schizophrenia became a black disease*. Beacon Press. referenced along drapetomania and wider issue at hand, the entire he body politic and the worse angels enforinc the law of men: add also feminicide and harsher societal control mechanisms to this proceedings paper introduction and discussion. Include reports on threats to the speakers and host, authorities denial.]

Political abuse of psychiatry refers to the deliberate misuse of mental-health diagnoses, treatments, or involuntary detention to punish, silence, or discredit dissenting individuals or groups. Van Voren (2009) explains that it means misuse of psychiatric diagnosis, treatment and detention to obstruct people's fundamental rights. Despite appearances to the contrary, such abuses have never been confined to openly authoritarian systems; even in established democracies there are documented instances of whistle-blowers and critics being stigmatized as mentally ill. Indeed, historical and

contemporary reports show that the tension between politics and psychiatry has been global and is an ongoing unresolved problem (van Voren, 2010).

The relatively recent historical record is stark. In Nazi Germany, psychiatrists were complicit in eugenic and punitive policies -a violation of their duty of care- using racist and ideologic criteria to justify locking up, deporting and killing disabled and political others (Narayan, 2013). In the Soviet Union during the Cold War, dissent was pathologized on a massive scale. Soviet psychiatrists proclaimed that critics were mentally ill, since no one would oppose their alleged best system unless insane, and often diagnosed dissidents with Snezhnevsky's made up sluggish schizophrenia diagnosis, a supposed mild form of schizophrenia whose symptoms conveniently included reform delusions or struggle for the truth (van Voren, 2010). Van Voren (2009) notes that in the 1970s-80s roughly one-third of all political prisoners in the USSR were confined in psychiatric hospitals. These practices sparked international outrage and led to the Soviet psychiatric society's suspension from the World Psychiatric Association in 1983. Other Eastern Bloc states followed suit to a lesser extent: for example, reports indicate that Romania under Ceaușescu systematically labeled hundreds of regime opponents as mentally ill (often for crimes like petitioning the authorities), resulting in mass psychiatric incarceration. Countries such as Cuba also implemented sometimes short-lived programs of detaining dissidents in mental institutions in the late 20th century. Notably, an unusual case in 1990s Netherlands showed that such abuse could occur in a democratic setting as well: a Dutch Defense Ministry official falsified psychiatric diagnoses to silence a social worker, a scheme later overturned by courts. These historical episodes - whether in Nazi Germany, the Soviet bloc, or isolated cases in the West - underscore that psychiatry has been repeatedly corrupted as a tool of political repression (Narayan, 2013).

At the root of genocides, purges, and systemic repression lies a recurring mechanism: the dehumanization of those labeled as feeble-minded, deviant, inferior, or unfit. Cognitive biases such as moral disengagement, group conformity, and the illusion of a just world, combine with a corrosive sense of superiority that gives moral cover to cruelty. This mindset easily merges with opportunism and criminality, providing social and material incentives for professionals and ordinary citizens to participate in abuse. Hatred becomes a path to belonging and prestige. In Nazi Germany, psychiatrists designed and implemented the Aktion T4 program, selecting tens of thousands of disabled individuals for extermination under the guise of medical necessity. These killings, sanitized through clinical language and bureaucratic process, laid the morals, mindset, rewards, technical, and institutional groundwork for the Holocaust and the Second World War itself (Friedlander, 1995). In the Soviet Union, psychiatry was weaponized to silence dissent: critics of the regime were declared insane and confined indefinitely, often tortured in the name of treatment (van Voren, 2010). These are not historical anomalies. From colonial asylums to apartheid psychiatry, from the Khmer Rouge to present-day internment and reeducation programs, the same logic persists. Racism, ableism, and political repression intersect with pseudoscience and institutional power, allowing medical torture to be reframed as care. Once any system presumes the authority to define sanity, worth, or humanity itself, it grants itself license to destroy. These practices are not only abuses of science and medicine, these are crimes that strike at the core of what our civilization claims to uphold. Failing to expose and dismantle these structures ensures their return, in new and old forms, again and again.

Table 1: Barriers to Political Abuses of Psychiatry

Domain	**Protective Factors**	**Vulnerabilities When Absent**

Legal Safeguards	Independent oversight, enforceable patient rights, access to justice	Arbitrary detention, impunity, unchecked coercion
Ethical Practice	External review boards, whistleblower protection, survivor-led ethics	Collusion, fear of reprisal, normalized violations
Clinical Approach	Shared decision-making, trauma-informed care, consent-based treatment	Forced interventions, disregard for autonomy
Training and Culture	Rights-based education, reflective practice, critical pedagogy	Authoritarianism, biomedical dogma, silencing of dissent
Economic Integrity	Transparent funding, non-profit care models, conflict of interest checks	Overmedication, neglect, market-driven interventions
Community Role	Peer support, advocacy groups, participatory service design	Isolation, stigma, lack of accountability
Public Awareness	Media scrutiny, civic engagement, open reporting channels	Denial, invisibility of harm, politicized psychiatric labels

Today, political psychiatry abuses persist in various countries. In the Russian Federation, rights groups and journalists report a revival of punitive psychiatry since 2022. Reuters (2025) found that dozens of anti-war activists and protesters have been ordered into psychiatric evaluation or detention by courts, a pattern reminiscent of the Soviet era (Peoples Gazette, 2025). One detailed case involved Yekaterina Fatyanova, an opposition journalist who was involuntarily hospitalized for two months after her paper published an anti-war article; letters she sent from the hospital describe unnecessary and degrading procedures, and she was finally discharged as mentally healthy. Robert van Voren, who has studied Russian psychiatry, documented roughly 20-30 such cases per year since 2022. In April 2025 a Moscow court also made international news by committing a U.S. citizen (Joseph Tater) to compulsory psychiatric treatment after annulment of criminal charges - a move observers likened to Soviet-era psychiatric coercion (Reuters, 2025). In neighboring Belarus, the authoritarian regime of Alexander Lukashenko has used psychiatric hospitals to punish critics of the 2020 elections. UN human-rights experts reported in early 2025 that at least 33 opposition figures have been coerced into undergoing psychiatric treatment for peaceful protest, with most still held indefinitely. Experts warn that this amounts to a grave violation of human rights, noting that many detainees are kept confined for months or years with no legal recourse (Trickey, 2025).

In the People’s Republic of China, too, multiple sources confirm severe ongoing abuses. A 2022 investigation published by Safeguard Defenders found that from 2015-2021 at least 99 petitioners and activists were involuntarily locked up in psychiatric facilities for political reasons, often without any legitimate diagnosis (Mou, 2022). The NGO concluded that forcing critics into mental hospitals is still widespread and routine in China today. These cases span the country: one recent report noted that courts routinely dispatch petitioners, petition filers, anti-corruption complainants and even labor activists to psychiatric wards under various pretexts. The victims describe arbitrary detention, forced medication, electroconvulsive therapy and repeated incarceration, all to silence dissent (The Washington Post, 2022). A prominent example is the so-called *Ink Girl,* Dong Yaoqiong, who in 2018 splashed ink on a poster of Xi Jinping; she was repeatedly committed to a psychiatric hospital, restrained to her bed and beaten for refusing treatment, despite being found mentally healthy each time. International observers note that Chinese abuse of psychiatry today involves far larger numbers of people than even the Soviet regime did, targeting followers of banned faiths (e.g. Falun Gong), human-rights lawyers, dissident petitioners and whistle-blowers.

Elsewhere in Asia and beyond, cases continue to surface. In Iran, for instance, a Lancet Psychiatry commentary (Wasserman *et al.*, 2023) described how a young student was forcibly hospitalized in Tehran after staging a protest against compulsory hijab laws, despite having no medical diagnosis - an act likened to political repression through psychiatry (World Psychiatric Association, 2025; The Lancet Psychiatry, 2025). Human-rights advocates in the U.S. have also warned of such misuse: historically, racist and political dissent have been pathologized: e.g. antebellum drapetomania for escaping slaves, and mid-20th-century civil-rights activists declared delusional (Edwards-Grossi, 2024). While overt examples in modern American politics are rare, the specter remains. Even well-established democracies have seen whistle-blowers subjected to psychiatric censure (van Voren, 2010). The overall pattern is clear: wherever political power is unchecked, there is incentive to brand opponents as mentally ill.

The political abuse of psychiatry has a long pedigree from Nazi and Soviet eras to today's China, Russia, Belarus and failing, corrupt systems elsewhere. It relies on fabricating or exaggerating psychiatric disorders to neutralize dissent without legal trial, violating medical ethics and human rights at every step (van Voren, 2010). Landmark investigations and recent human-rights reports show that this practice persists under new guises. While the number of countries openly running such programs has declined since the Cold War (van Voren, 2009; Narayan, 2013), current evidence underscores that political psychiatry remains very much a present-day issue. Authorities in repressive regimes, and corrupt institutions in democracies, continue to weaponize mental-health institutions to stigmatize and silence critics (Mou, 2022). Contemporary sources make clear that each claim of involuntary psychiatric commitment for political reasons must be scrutinized as a potential human-rights abuse.

Symposium Presentation

The International Symposium on the Political Abuse of Psychiatry convened between October 1 and November 11, 2023, gathering leading experts, survivor advocates, and human rights scholars to systematically examine the persistence and mechanisms of psychiatric abuses worldwide. Organized independently after the rejection of formal inclusion within the World Psychiatric Association's (WPA) Vienna conference premises, the symposium unfolded across a series of virtual and recorded sessions, ensuring free and rigorous exchange of evidence and strategies for reform.

[Pending naming confirmation and permission to include or not a mention on van Voren's satellite event organized concurrently in Vienna by partner organizations may be referenced here.]

Table 2: Symposium Speakers, Topics Covered, and Core Focus

Speaker(s)	Topic Covered	Core Focus
Alejandra Gandolfi	Mental healthcare and discrimination against Moroccan migrants in Spain	Systemic Abuse
Al Galves	Critique of the biomedical model and promotion of holistic mental health care	Systemic Reform, Survivor Advocacy
Cathy Wield	Informed consent and psychiatric detention from a survivor-doctor perspective	Survivor Advocacy, Human Rights
Chris Munt	Survivor testimony on psychiatric	Survivor Advocacy

	violence in the UK	
Dainius Pūras	Human rights and mental health from a UN perspective	Human Rights
David Matas	Psychiatric abuses linked to organ harvesting in China	Human Rights, Legal Frameworks
Edel Granda	Psychiatric pathologization of transgender individuals	Human Rights
Hel Spandler	Structural coercion in UK mental healthcare	Systemic Abuse
Itxaso & Olaya (Orgullo Loco Madrid)	Grassroots activism against psychiatric coercion in Spain	Survivor Advocacy
Lidea Losa & Xisca Morell	Psychiatric abuses and guardianship issues in Spain	Systemic Abuse, Survivor Advocacy
Manuel Llorens	Political psychiatric abuses during Venezuela's health system collapse	Systemic Abuse
Murphy Halliburton	Importance of transcultural psychiatry to counter biomedical dominance	Transcultural Psychiatry
Paola Di Maio	Systems view of psychological coercion in mental health	Systemic Abuse
Peter Groot	Medication withdrawal and the right to taper safely	Survivor Advocacy
Peter Lehmann & Craig Newnes	Historical and contemporary human rights abuses in Europe	Systemic Abuse
Petr Winkler	Reforming Czech psychiatry to protect human rights	Legal Frameworks, Human Rights
Sarah Smith	Mutual aid networks resisting psychiatric abuses (MindFreedom SHIELD)	Survivor Advocacy
Yanxi Mou	China's black prisons and extrajudicial psychiatric detention	Human Rights
Yutong Zhang	Psychiatric repression of dissenters in the PRC	Human Rights

Participants brought distinct and crucial expertise. Dainius Pūras, former United Nations Special Rapporteur on the right to health, provided critical insights on the systemic contradictions between psychiatric practice and human rights frameworks, grounding the discussions in international legal obligations. Peter Lehmann, survivor advocate and founder of the European Network of (Ex-)Users and Survivors of Psychiatry, and Craig Newnes, clinical psychologist and critical psychiatry scholar, contributed an essential historical and experiential analysis of coercive practices across European contexts. Peter Groot, research scientist and leading proponent of individualized medication withdrawal solutions, introduced evidence-based strategies to dismantle forced chemical management. Alejandra Gandolfi, anthropologist, illuminated the intersections between psychiatric marginalization and cultural displacement, particularly within Spain's Moroccan communities.

Hel Spandler, editor of *Asylum: The Magazine for Democratic Psychiatry*, critically examined systemic coercion within the UK mental health system. Chris Munt, survivor and advocate, shared firsthand accounts of abuses in British psychiatric care, highlighting the normalization of violence. Paola Di Maio, systems scientist, articulated a structural model explaining how coercion infiltrates

mental health services through psychological and systemic mechanisms. Edel Granda, activist and advocate for transgender rights, foregrounded the pathologization of gender non-conformity as a key dimension of psychiatric oppression.

Murphy Halliburton, professor of anthropology specializing in transcultural psychiatry, emphasized the necessity of integrating cultural and social understandings to counter hegemonic biomedical dominance. Manuel Llorens, Venezuelan psychologist and academic, documented the collapse of healthcare structures and their exploitation for political repression. David Matas, human rights lawyer and Nobel Peace Prize nominee, provided a legal and forensic perspective on the psychiatric and organ harvesting abuses perpetrated in China. Yutong Zhang and Yanxi Mou, Chinese human rights defenders, exposed the systematic use of psychiatric detention to silence dissent, presenting detailed documentation and survivor testimonies.

Sarah Smith, activist with the SHIELD MindFreedom network, shared strategies for survivor-led mutual aid and resistance against coercive psychiatry. Petr Winkler, director of the Czech National Institute of Mental Health, contributed a case study on rights-centered psychiatric reform within a post-totalitarian context, offering a potential model for systemic transformation. Al Galves, clinical psychologist and author, critically assessed the biomedical model's failures in the United States and outlined paths toward holistic and voluntary mental health care.

Derek Summerfield critically examined the global mental health movement, emphasizing how Western psychiatric models are often exported into diverse cultural contexts without sufficient adaptation or scrutiny. He argued that this expansion often perpetuates medicalized understandings of distress while sidelining social, political, and economic determinants of suffering. Summerfield warned that global mental health initiatives, although framed as humanitarian, can become vehicles for the homogenization of psychiatric practices and facilitate new forms of coercion and marginalization. His intervention underscored the need to critically interrogate not only national abuses of psychiatry but also how international agendas risk replicating systemic failures under the guise of global health promotion, thus reinforcing rather than dismantling structures of oppression.

Each participant’s contribution was integral to constructing a comprehensive, interdisciplinary understanding of how psychiatry, when severed from its ethical foundations, becomes vulnerable to criminal misuse, political repression, and systemic failure. Their collective expertise underscored the necessity of principled, multidisciplinary action to reclaim psychiatry for healing, freedom, and dignity.

Mechanisms of Abuse (Psychiatric, Psychological, Social)

Across the independent presentations at the symposium, a detailed portrait emerged of the mechanisms by which psychiatry is weaponized against individuals. These mechanisms, operating simultaneously at psychiatric, psychological, and social levels, reflect a shared understanding among the speakers that abuses today are systemic, severe, and require immediate redress.

Table 3: Historical and current cases of political abuse of psychiatry

Country	Period	Target Group	Type of Abuse Documented
Soviet Union	1950s–1980s	Political dissidents, human	Forced hospitalization,

		rights activists	chemical restraint, isolation
China	1990s–present	Petitioners, Falun Gong members, dissidents, ethnic minorities	Forced hospitalization, chemical restraint, organ harvesting and trafficking
Russia	1960s–1980s; resurgence post-2010	Political dissidents (historical); anti-war protesters (current)	Forced psychiatric evaluation, silencing, social stigma
Belarus	2020s–present	Political protesters, journalists	Coercive hospitalization, stigmatization
Venezuela	2010s–present	Political opponents, dissidents	Forced psychiatric confinement, political intimidation
United States	1950s–1970s	Civil rights activists, indigenous communities, antiwar protesters	Wrongful institutionalization, psychiatric silencing
United Kingdom	1970s–1990s	Persons labeled as dangerous, racial and ethnic minorities	Overuse of detention, coercion in psychiatric care
Spain	1936–1980s (Civil War, Dictatorship, Post-dictatorship)	Political prisoners, dissidents, social minorities	Political repression via psychiatric institutions, social control through diagnosis

At the psychiatric level, Peter Lehmann and Craig Newnes highlighted the way in which forced treatment practices are justified through diagnostic constructs that lack rigorous clinical basis in many cases. They emphasized that psychiatric categories are often expanded to encompass a wide range of socially undesirable behaviors, facilitating involuntary hospitalization under vague pretexts (Lehmann & Newnes, 2025). Peter Groot's intervention on the use of tapering strips illustrated another dimension: the over-medicalization and long-term chemical control of individuals under the guise of psychiatric care. He noted that psychiatric drug regimens, initially imposed under coercive circumstances, are rarely reviewed critically, leading to dependency and the erosion of autonomy (Groot, 2025).

Psychological mechanisms were particularly illuminated through the testimonies of survivors. Chris Munt described how everyday practices within psychiatric institutions, including threats, humiliation, and arbitrary use of restraint, foster a climate of terror rather than healing (Munt, 2025). Sarah Smith added a critical dimension by explaining how psychiatric labeling leads to profound identity destabilization. Once classified as mentally ill, individuals find their narratives invalidated, their perceptions systematically doubted, and their autonomy curtailed, creating a cycle of learned helplessness (Smith, 2025). Hel Spandler's analysis of UK psychiatric reforms suggested that, despite superficial procedural safeguards, the underlying culture of distrust toward patients remains pervasive, maintaining psychological coercion even where formal rights protections exist (Spandler, 2025). Orgullo Loco Madrid provided a critical intervention focused on the systemic failures of the Spanish mental health system from the perspective of the user and survivor movement. They emphasized how psychiatric institutions continue to function as mechanisms of control and silencing, rather than as spaces of healing and support. The speakers highlighted the persistence of coercive practices, including involuntary hospitalization and forced medication, often justified under paternalistic frameworks that deny the autonomy and voice of the individuals affected. They further stressed the structural marginalization of survivors in both clinical practice

and policymaking, calling for a radical transformation toward user-led, rights-based, and emancipatory models of mental health care. Their testimony underscored the need to recognize psychiatric oppression as a form of political and social violence embedded in broader patterns of discrimination and exclusion.

At the social level, Edel Granda's presentation on transgender rights revealed how psychiatric structures are employed to marginalize already vulnerable populations. She argued that pathologizing gender non-conformity perpetuates systemic exclusion and medical violence under the veneer of care (Granda, 2025). Lidea Losa and Xisca Morell provided a powerful account of how Spanish psychiatric institutions often use legal and social levers, such as guardianship regimes, to strip individuals of civil rights, making abuse both invisible and legally sanctioned (Losa & Morell, 2025). Dr. Paola Di Maio expanded the systemic view by framing psychiatric coercion as part of broader systems of psychological control in society, wherein labeling, enforced dependency, and isolation function as tools to suppress dissent and difference (Di Maio, 2025).

Together, although articulated independently, these contributions outlined a sophisticated model of how political, institutional, and interpersonal forces converge to perpetrate psychiatric abuses. The resulting mechanisms are not incidental but structurally embedded, calling into question the very ethical foundations of current mental health practices in many contexts.

Thematic Synthesis of Symposium Discussions

The thematic convergence of the symposium was clear: despite differing geographical focuses and analytical lenses, speakers consistently revealed the persistence, gravity, and systemic character of psychiatric abuses. No formal consensus process occurred during the event, but the independent presentations together illuminated critical thematic patterns.

One central theme was the **instrumentalization of psychiatric diagnosis**. David Matas, focusing on China’s organ harvesting practices, explained that psychiatric labels are used strategically to delegitimize political and religious dissidents, facilitating both their disappearance and commodification (Matas, 2025). Similarly, Yutong Zhang detailed how psychiatric diagnoses in China are weaponized against petitioners and activists, with forced hospitalization serving as a method of silencing (Zhang, 2025).

Another recurring theme was the **role of forced treatment and chemical control**. Peter Groot’s exposition on tapering strips underscored how psychiatric medication regimens, often initiated under coercion, become chronic mechanisms of control rather than care (Groot, 2025). This point resonated with the broader critique articulated by Chris Munt and Al Galves, who emphasized that in the UK and USA respectively, institutional psychiatry often prioritizes chemical restraint over addressing the underlying social or psychological distress of individuals (Munt, 2025; Galves, 2025).

Table 4: Mechanisms Abuse: Subterfuges, Methods, and Enabling Conditions

Subterfuge or Foul Play	Method Employed	Path to Extrajudicial Locking	Permissive Factors
Fabrication of mental instability	Spreading rumors, false reports, character	Initiates involuntary psychiatric evaluation	Weak legal standards, corruption in healthcare and

	assassination	without cause	law enforcement
Provocation into reactive behavior	Harassment, isolation, threats	Victim's natural defense misinterpreted as psychiatric symptoms	Institutional bias, failure to investigate impartially
Forced biological destabilization	Sleep deprivation, food deprivation, chemical agents	Induces cognitive or emotional breakdowns misused as justification	Medical malpractice, collusion between non-medical and psychiatric actors
Misdiagnosis and diagnostic inflation	Deliberate exaggeration or falsification of symptoms	Grounds for commitment without independent review	Inadequate oversight, professional impunity
Coerced testimonies	Pressuring family or associates to corroborate false claims	Falsified support for psychiatric intervention	Fear, loyalty conflicts, systemic impunity
Weaponized guardianship or custody abuse	Manipulating civil legal processes	Enables psychiatric confinement under pretenses of protection	Lack of transparency, judicial rubber-stamping
Administrative shortcuts and procedural abuses	Detention without proper judicial authorization	Administrative detention masked as medical necessity	Low accountability in bureaucratic and health systems
Abuse of emergency psychiatric holds	Misuse of short-term *crisis* detention powers	Converts temporary holds into extended confinement	Loopholes in mental health laws, lack of mandatory reviews

The tactics identified in the table above are not limited to authoritarian or politically repressive systems. Similar patterns are visible in domestic violence cases, organized crime, and systemic failures in regular healthcare settings. In domestic environments, abusive partners, family members, or associates may similarly provoke, destabilize, or falsely accuse victims to gain control, silence dissent, or exploit vulnerabilities. Organized crime networks may weaponize mental health accusations to intimidate or remove threats without legal processes. Even within ostensibly democratic societies, negligent or corrupt actors within healthcare systems may collude to achieve unlawful psychiatric detention for convenience, financial benefit, or retaliation. The intersection of psychiatry with broader systems of political and social repression emerged prominently. Manuel Llorens described how in Venezuela, psychiatric detention has been repurposed as a tool to neutralize political opponents, with little concern for medical legitimacy (Llorens, 2025). Yanxi Mou's testimony on China's black prisons showed how psychiatric justifications are created post hoc to enable extrajudicial detention without legal oversight (Mou, 2025).

The de-legitimization and isolation of victims was another major theme. Sarah Smith and Edel Granda highlighted how individuals labeled as mentally ill, particularly those from already marginalized communities, experience profound social exclusion, often compounded by institutional betrayal and public stigma (Smith, 2025; Granda, 2025). Dr. Paola Di Maio's systems analysis reinforced this, positing that psychiatric practices of categorization and containment mirror broader societal mechanisms of control and marginalization (Di Maio, 2025).

A thread of human rights protection and ongoing reform ran through many contributions as well. Dainius Puras stressed the international human rights framework that obliges states to move toward non-coercive, rights-respecting mental health systems, though he acknowledged the gap between principle and practice remains vast (Puras, 2025). Petr Winkler provided a cautious example of progress, outlining how the Czech Republic has undertaken systemic reforms embedding human

rights into psychiatric care, though challenges persist in implementation (Winkler, 2025). It is agreed that addressing the systemic vulnerabilities leading to abuses, medical torture and extrajudicial killings requires more than procedural reforms. Healthcare systems must be reconstructed on principles of strict transparency, due diligence, and external accountability. Every psychiatric intervention must be independently reviewable, open to audit, and subject to clear, enforceable legal standards. Honest professionals, ethical medical bodies, and judicial systems must coordinate to prevent and punish abuse without exception. Survivors' testimonies must be central to reform. Denial of these realities only perpetuates harm. Recognizing and confronting these abuses directly is essential to building medical and legal systems that protect health, dignity, freedom, and fundamental human rights for all.

Table 5: Mechanisms of Abuse – Framing and diagnosis leading to psychiatric incarceration

Psychiatric Diagnosis Used	Legal Status of Detention	Explanatory Relevance	Framing Methods
Sluggish schizophrenia, paranoia	Involuntary civil commitment	Indefinite detention via vague symptoms	Isolation, sleep deprivation, induced confusion
Political mania, paranoia, delusional disorder	Administrative detention, extrajudicial internment	Bypassed judiciary, mass suppression	Harassment, defamation, staged accusations
Paranoia, delusional disorder, any excuse	Civil and forensic commitment	Silencing dissenters, profiting, threatening	Entrapment, covert intimidation
Schizophrenia, psychopathy	Court-ordered psychiatric examination	Protest repression, socioeconomic control	Hostile confinement, coercive interrogation
Non-specified psychotic disorders	Arbitrary administrative detention	Flexible repression tool	Deprivation of needs, induced agitation
Schizophrenia, sociopathy, bipolar disorder	Civil commitment, misuse of psychiatric testimony	Suppressing activism	Manipulated testimony, emotional framing
Schizophrenia, antisocial personality disorder	Involuntary commitment	Racial and social control	Profiling, criminalization of poverty behaviors
Paranoid psychosis, manic-depressive disorder	Arbitrary internment, punitive civil commitment	Political repression	Surveillance, rumor-spreading, social isolation

[Add beatings, threatening, spiking, family abuses, destabilization by any means. Point at same means in cases of domestic abuse, systemic violence, brutality from forces, all that drags and mask inflicted suffering as a disease, disorder, illness of the victims, on top of medical torture. Delve into structural violence and all excuses to keep on holding systems of care unable to work it out, heal.]

Although speakers came from diverse backgrounds and contexts, their presentations converged implicitly around the recognition that psychiatric abuses are not relics of the past but ongoing systemic violations. They underscored the urgency of confronting these abuses through legal, institutional, and cultural transformation, while highlighting that many victims today remain invisible, unprotected, and unheard.

The weaponization of psychiatry and the manipulation of media narratives operate symbiotically to maintain systemic oppression. Psychiatric institutions, when subordinated to political or social agendas, provide a veneer of medical legitimacy to acts of repression, framing resistance, trauma, or nonconformity as clinical disorders. Media outlets, whether through active propaganda or passive

repetition of official narratives, sanitize these abuses, diffusing public outrage and transforming grave violations into mere episodes of private tragedy. This convergence facilitates the erasure of victims' political agency, decontextualizing their suffering and reinforcing hegemonic control. In environments where dissent is criminalized through medicalization, and where suffering is depoliticized through media framing, the possibilities for justice diminish radically. The challenge, therefore, lies not only in exposing individual abuses but in systematically dismantling the interlocking structures that allow psychiatric authority and mass communication to be deployed as tools of silencing, erasure, and social domination.

Ongoing cases, contemporary patterns and regional examples

The international legal framework explicitly prohibits the use of medical interventions to inflict pain, suffering, or coercive control. The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT, 1984) directly criminalizes acts of torture, including those perpetrated under the guise of medical treatment. Furthermore, the Principles of Medical Ethics Relevant to the Protection of Prisoners and Detainees against Torture (adopted by the UN General Assembly in 1982) expressly forbid health professionals from participating in or condoning any form of torture or degrading treatment. The Rome Statute of the International Criminal Court (1998) recognizes torture as a crime against humanity, regardless of whether it occurs inside medical institutions.

Despite these robust legal standards, enforcement regarding psychiatric abuses has been alarmingly deficient. Medical torture laws are theoretically comprehensive but rarely applied to psychiatric settings. Several factors contribute to this impunity: the medicalization of harm cloaks abusive practices in clinical legitimacy; psychiatric patients are often deemed unreliable witnesses; and judicial systems are generally reluctant to intervene in medical affairs unless overwhelming evidence is presented. Furthermore, systemic biases continue to downplay coercion within psychiatry as merely a clinical necessity, rather than recognizing it as a potential act of torture.The regional examples presented at the symposium painted a sobering picture of psychiatric abuse's current global landscape.

In China, Yutong Zhang and Yanxi Mou provided complementary insights into the systematic use of psychiatric detention against political dissidents and minority groups. Zhang described a bureaucratic machinery that facilitates psychiatric abuse at both local and national levels, while Mou detailed the existence of clandestine detention centers operating outside any legal framework, where psychiatric justifications are retrofitted to disappear detainees (Zhang, 2025; Mou, 2025). Manuel Llorens's presentation on Venezuela revealed that psychiatric institutions are being used to enforce political loyalty and punish dissent. He recounted specific cases where activists were diagnosed with fictitious mental illnesses and confined without due process (Llorens, 2025). In the United Kingdom, Hel Spandler and Chris Munt independently reported that while overt political abuses are rare, systemic coercion remains endemic within mental healthcare. Patients, particularly from marginalized backgrounds, continue to experience involuntary commitment, forced medication, and the delegitimization of their narratives through psychiatric labeling (Spandler, 2025; Munt, 2025). Al Galves's analysis of the United States echoed these concerns. He argued that despite legal protections, psychiatric abuses persist through mechanisms such as outpatient commitment, guardianship laws, and the dominance of the biomedical model, which often overrides

patient autonomy (Galves, 2025). In the Czech Republic, Petr Winkler presented a more hopeful picture. He described how systemic reforms have begun to reorient psychiatric care toward human rights and community integration, offering a model for other countries, although he cautioned that changing institutional cultures remains an ongoing challenge (Winkler, 2025). Finally, Edel Granda emphasized that psychiatric abuses intersect with other axes of oppression, such as gender identity. She noted that transgender individuals continue to be pathologized in many mental health systems, leading to denial of care, coercion, and social marginalization (Granda, 2025).

Taken together, these regional reports demonstrate that while the forms and intensity of psychiatric abuse vary, the underlying patterns of coercion, de-legitimization, and systemic violence remain pervasive across political systems and cultural contexts. The urgent need for reform is not limited to any single country or regime but is a truly global imperative. Given the overwhelming evidence from historical and contemporary abuses, it is clear that medical torture laws must be interpreted and enforced to include psychiatric abuses without delay. Non-consensual interventions performed without immediate life-threatening justification, prolonged and coercive hospitalizations, punitive uses of psychiatric confinement, and medical practices aimed at suppressing political, social, or personal dissent must be recognized not as mere clinical misjudgments, but as grave human rights violations. Applying medical torture statutes consistently would dismantle the protective shield of clinical language often used to sanitize abuse. It would also affirm the universality of human dignity and bodily autonomy, whether in prisons, interrogation rooms, hospitals, or psychiatric wards. This shift demands not only judicial courage but also structural reform in how psychiatry is monitored, regulated, and held publicly accountable.

Building sustainable and principled momentum for reform

The urgency and severity of the abuses documented throughout the symposium highlight the necessity of not merely identifying failures, but actively constructing sustainable, principled momentum toward the full reform of psychiatric, psychological, and broader mental health services. Acknowledging the profound historical and ongoing harm inflicted through coercive practices is a prerequisite for any genuine transformation. Equally critical is recognizing the unprecedented opportunity to rebuild systems grounded in science, ethics, dignity, and human rights, leaving behind the entrenched ideologies and defensive structures that have long shielded institutions from necessary accountability. The enforcement of internalized abusive laws often transcends formal state structures, becoming embedded in the practices of healthcare services, family members, and the broader community. Psychiatric systems, when weaponized, do not operate in isolation; they are supported and reinforced by social actors who absorb, normalize, and propagate the underlying ideologies of coercion. Families, under pressure or seeking control, may initiate involuntary psychiatric processes against dissenting members, framing personal conflicts as clinical crises. Entire communities, steeped in stigma and fear, readily accept the marginalization and silencing of individuals labeled mentally ill, conflating nonconformity with pathology. Healthcare services themselves, functioning under regulatory frameworks that legitimize coercive practices, internalize and routinize violations of autonomy as professional standards. This collective complicity transforms abuse into a moral imperative: actions such as forced hospitalization, overmedication, or guardianship stripping are perceived not as violations, but as socially sanctioned duties. Similarly, in corrupted environments, ordinary crime assumes the guise of moral enforcement. Acts of

violence, deceit, and systemic destruction are perpetrated under the rationalization of protecting order, family, or national security. The body politic thus operates not merely through official decrees but through the diffuse internalization of oppressive premises, enabling entire populations to participate in, and sustain, the political abuse of psychiatry and other forms of institutional violence without critical reflection. Addressing this phenomenon requires dismantling not only abusive laws but the cultural and moral structures that legitimize their application at every social level.

[Add table]

Efforts to reform mental health care cannot be piecemeal, symbolic, or dependent solely on voluntary professional adaptation. Structural and cultural change must be driven by a coordinated strategy that addresses all levels of the system simultaneously. Entrenched actors - whether professional associations, political authorities, financial interests, or institutional bureaucracies - that resist transparency, accountability, or survivor leadership must be actively challenged and displaced from positions of influence. The tolerance of denial, minimization, or complicity with coercive practices can no longer be accepted under the guise of stability or tradition.

Education stands at the center of this transformative agenda. Immediate, mandatory retraining initiatives must be launched across all sectors of mental health services - from psychiatry and psychology to social work, nursing, and administrative leadership. Training programs must fully integrate human rights standards, trauma-informed methodologies, and critical analyses of past abuses. Curricula must be redeveloped to reflect the best available medical, psychological, and social science evidence, emphasizing voluntary, person-centered, interdisciplinary approaches to care. Crucially, this education must not remain theoretical but must be translated directly into clinical, administrative, and legislative practice.

Every psychiatric clinic, general hospital, mental health center, oversight body, and legislative framework must be reoriented to implement these principles. Institutions must embed binding protocols that ensure respect for autonomy, informed consent, dignity, and non-discrimination. Oversight mechanisms must be granted real power to enforce compliance and address violations swiftly and transparently. Legislation must codify rights protections not as optional standards but as enforceable guarantees, fully aligning domestic legal frameworks with international human rights obligations.

To ensure this translation into practice, interdisciplinary implementation teams - combining legal experts, human rights monitors, trauma specialists, survivor advocates, and medical professionals - must be deployed to guide reforms, audit institutions, and monitor compliance over time. The success of these efforts must be evaluated not by institutional self-reporting but by measurable outcomes: reductions in coercive interventions, increased voluntary engagement, survivor satisfaction, and documented improvements in community well-being.

The opportunity to build serious, effective momentum for psychiatric and psychological reform exists now. But it demands abandoning self-protective narratives, acknowledging the systemic nature of past and present harms, and committing to a future where mental health services protect, heal, and empower rather than control, silence, or destroy. The responsibility is collective, and the obligation is urgent: to restore mental health care to its rightful place - as a foundation for human dignity, social justice, and true healing.

Reform at the International Level

Strengthen and enforce international legal standards: States should fully implement the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and related treaties. In particular, governments must heed the CRPD Committee's call to ban all non-consensual psychiatric interventions and involuntary hospitalization. International human rights bodies (UN Special Rapporteurs on health, torture, and disability, the UN Human Rights Council and Universal Periodic Review, etc.) should systematically monitor mental health laws and practices, issuing binding recommendations. Global institutions like the World Health Organization should integrate human rights and trauma-informed care into their mental health guidelines, requiring UN member states to shift resources from coercive institutions to community-based supports. International funding mechanisms (WHO, World Bank, philanthropy) must prioritize alternatives to institutional care and psychosocial rehabilitation, as urged by former UN Rapporteur Dainius Puras.

Insulate mental health services from criminal and non-medical abuses: International cooperation is needed to expose and punish abuses such as organ trafficking and extrajudicial detention. For example, medical associations worldwide should demand the release of psychiatric prisoners (e.g. Falun Gong detainees) and denounce illicit organ procurement. Global psychiatric and transplant societies ought to refuse submissions and presentations from organizations that cannot demonstrate ethical sourcing of transplant organs. Diplomatic pressure and targeted sanctions (e.g. Magnitsky-style human rights sanctions) can deter regimes that misuse psychiatry for political ends. Coordinated action by United Nations agencies (OHCHR, WHO, OPCAT) and international NGOs must expose black jails and punitive psychiatric detention centers, and call for their abolition.

Global promotion of human-rights-based mental health: The UN and regional bodies should sponsor public campaigns and capacity-building to promote trauma-informed, person-centered care. A global panel of experts (including survivors and trauma specialists) could develop best-practice guidelines (on preventing re-traumatization, respecting autonomy, etc.), which countries would be expected to adopt. Education initiatives under UNESCO or WHO could train health, police and justice officials in survivors' rights. Finally, international networks of survivors and advocates (such as MindFreedom International) should be supported to share strategies and hold governments accountable.

Reform at the National Level

Legislative reform and enforcement: Each country must align its mental health and disability laws with human rights norms. This means repealing or tightly restricting involuntary commitment laws, abolishing coercive treatments (force medication, restraint, ECT without consent), and ensuring due process with effective legal representation. Governments should enact parity laws so that insurance/Medicare covers holistic care (housing, therapy, peer support) as well as medication. For instance, while Medicaid/Medicare in the U.S. pays for psychiatric drugs, it will not fund non-medical alternatives like Soteria houses. National policy must close such gaps: insurers and public health programs should cover community-based recovery services (residential supportive housing, peer-run respite centers) to prevent re-institutionalization.

Dedicated funding and resources: Budgets must shift from custodial hospitals to community supports. Governments should prioritize and fund a spectrum of psychosocial rehabilitation and recovery programs. This includes crisis outreach teams, supported employment, education and housing initiatives. Victims must have rapid access to counseling, legal aid and compensation;

funding for victim protection programs should be guaranteed. Transparency in spending is essential to deny misuse of resources by corrupt interests (for example, requiring public reporting of hospital bed occupancy and preventing profiteering from involuntary care).

Oversight and accountability: Establish independent national monitoring bodies (ombudsperson or inspectorates) to oversee all psychiatric and custodial facilities. Human rights commissions and parliaments should have the power to audit institutions, investigate complaints, and prosecute abuses. Professional licensing boards must sanction clinicians who violate patients' rights or collude with non-medical actors. Strict conflict-of-interest rules should bar psychiatrists from receiving undisclosed payments from pharmaceuticals, prisons, or security agencies. Law enforcement must have clear protocols to prevent police from using psychiatric detention for social control or evidence collection. Any deviation by staff (such as nepotistic confinement or unlawful experimentation) must carry criminal liability.

Education and training: Mandatory human-rights and trauma-informed training is needed for judges, police, healthcare workers, and community leaders. For example, curricula for medical, nursing and law courses should include the CRPD, survivors' perspectives, and the dangers of coercion. Public education campaigns can inform families and communities about the *dignity* and autonomy of persons with psychosocial disabilities, countering stigma. Ensuring services meet victims' needs also means providing culturally appropriate care: curricula should include transcultural psychiatry and diverse healing practices, so that indigenous, spiritual and minority groups receive respectful support.

Community safety nets and re-traumatization prevention: National guidelines should require that all victim support services be trauma-sensitive. For example, emergency shelters and clinics must avoid punitive environments (no locked wards or invasive security checks unless absolutely necessary). Safeguards against re-traumatization include no use of prone restraint or sensory deprivation, and routine screening for prior trauma so clinicians can adapt care. Rehabilitation programs should be voluntary and empowerment-focused; consent must always be sought (even for psychotherapy, support groups, etc.). Patient advocacy laws (such as advance directives or treatment agreements) can strengthen autonomy.

Reform at the Institutional Level

Rights-respecting clinical care: Hospitals and clinics must integrate human rights at every level of care. Treatment plans should be co-produced with patients, emphasizing *recovery, dignity and communication*. Institutions should implement open-door policies wherever safe, eliminate unnecessary locking of wards, and use restraint only as a last resort with strict oversight. Staff must conduct debriefing after any coercive intervention and offer immediate apologies and support to the individual. Multidisciplinary ethics committees (including legal experts and survivor representatives) should review contentious cases (e.g. capacity issues). Enforceable patient charters should be posted, detailing rights (to refuse treatment, to an independent advocate, to dignity, etc.) and providing confidential complaint channels.

Trauma-informed environment: Facilities should be designed and operated to minimize trauma triggers. This includes quiet spaces, privacy, and options (e.g. single rooms if requested). Staff should receive trauma-awareness training so that simple actions (a calm tone of voice, asking permission before touching) become routine. Every institution needs permanent peer-support workers or counsellors (people with lived experience) available to help victims navigate the system.

Models like *Soteria houses* or peer-run crisis centers can be embedded in the health system as alternatives to hospitals - ensuring that voluntary, non-medical recovery options exist.

Staff selection and oversight: Screening and monitoring of personnel must weed out those who might exploit patients (any connections to criminal gangs, forced labor schemes, etc. should disqualify them). Ongoing human-rights auditing (possibly in partnership with NGOs) can quickly detect abuse patterns. Whistleblower protections and mandatory reporting rules will deter cover-ups. Institutions should use external reviewers for deaths or serious injuries in custody, ensuring families and human-rights groups can observe investigations. Violations must lead to swift disciplinary action or legal consequences, enforcing a culture of zero tolerance for human-rights abuse.

Services tailored to victims: Hospitals and care programs should be adapted to victims' specific needs. This means readily available translators, gender-sensitive care, and services for special populations (LGBTQ+, refugees, indigenous people). Psychosocial supports (occupational therapy, art/music therapy, peer groups) are integral - not optional extras. For example, trauma survivors often benefit from narrative therapy or community healing circles, rather than just medication. Implementing restorative justice options (apologies from institutions or compensation funds) can help victims reclaim dignity and trust.

Reform at the Community and Civil Society Level

Empower survivor and peer networks: Civil society must be at the forefront of reform. Governments should fund and partner with organizations run by people with lived experience (psychiatric survivors, families, activists) as equal stakeholders. Mutual-aid groups like the SHIELD MindFreedom network and the UK Paranoia Network (formed by survivors) demonstrate the power of peer support. Such groups can offer peer counseling, crisis respite homes, and advocacy training. Community grants should enable survivors to organize town halls and advise local health agencies on victims' needs.

Public education and stigma reduction: Grassroots campaigns can shift public attitudes about mental health and rights. For example, mental health first-aid training in schools and workplaces can emphasize listening and respect over medicalization. Public service messaging, in collaboration with media and influencers, should promote stories of recovery and neurodiversity, challenging notions of *madness* as shameful. Community leaders (faith groups, local councils) can host seminars on how to support victims and prevent abuse.

Watchdog and advocacy role: Independent NGOs and professional associations should monitor compliance at local levels. They can publish reports on human-rights conditions (as human-rights researchers in China and elsewhere have done) to alert the world to abuses. Civil society should use legal tools (strategic litigation, amicus briefs) to enforce rights - for instance, Czech activists succeeded in halting forced ECT by appealing to legislators and invoking UN reports. Journalists and public watchdogs should be trained to identify and report coercive practices. Moreover, alliances between survivor groups, lawyers, and mental health professionals can lobby for meaningful reform (e.g. amendment of outdated laws).

Community-based healing and prevention: Local programs - such as anti-violence initiatives, substance abuse recovery groups, and cultural healing practices - can address the root causes of trauma and distress, reducing demand for coercive psychiatry. Civil society can establish trauma-competent community centers offering free counseling and social support. Partnerships with schools

and youth organizations are key to early intervention: educators and parents should learn to recognize distress and engage supportive networks before crises escalate to psychiatric detention.

Reform at the Professional Level

Personalized, trauma-informed care: Each victim's experience is unique. Clinicians and counselors should conduct thorough assessments that include personal history of abuse. Therapeutic approaches must be empowering - for example, providing choices in treatment plans, encouraging patient goal-setting, and using non-triggering techniques. Victims should have access to professional trauma counseling, cognitive-behavioral therapy, or EMDR if appropriate, always on a voluntary basis. Service providers must actively avoid any practice that could re-traumatize (e.g. invasive procedures without consent, or humiliation).

Peer and self-help resources: Individuals benefit greatly from connecting with others who have had similar experiences. Support groups (in person or online) allow survivors to share coping strategies and find solidarity. Self-help resources - such as survivor-authored books, podcasts, and recovery workbooks - should be made widely available. Mentorship programs pairing veterans of the system with newer survivors can foster hope.

Holistic rehabilitation: True recovery involves rebuilding life skills and social ties. Victims should receive help with education, vocational training, and housing stability. Programs like supported employment or disability-inclusive microfinance empower independence. Creative therapies (art, drama, music) and wellness activities (yoga, meditation, nature retreats) can aid healing. By validating each person's dignity and capacity, providers reinforce that *sanity* encompasses far more than symptom checklists.

Legal and rights support: On an individual level, victims need clear information about their rights and remedies. All victims should be offered legal counsel to challenge unjust treatment or obtain reparations. Social workers or patient advocates must guide them through any appeals or complaints processes. Finally, respecting freedom means acknowledging survivors as experts in their own care - institutions should routinely solicit and implement survivor feedback on services.

Throughout all levels, enforcing human rights strictly must be non-negotiable. Any violator - whether a state actor, institution, or individual professional - must be held accountable under the law. By combining top-down legal protections with bottom-up community empowerment and person-centered services, the system can transform from one of coercion to one of healing, dignity and true recovery.

Table 6: Human and Economic Burden Estimate of Political Psychiatric Abuse

Region/Country	**Estimated Annual** Economic Burden (EUR)	**Human Cost Indicators**	**Sources and Basis**
China	Unknown (extremely severe)	Tens of thousands detained; severe trauma; intergenerational distrust	Safeguard Defenders (Mou, 2022); Human Rights Watch (2005); Matas (2025)
Russia	Approx. €460 million+ (wrongful detentions, productivity loss)	Thousands of political dissenters psychiatrically confined	Smith, van Voren, & Liebrenz (2024); Peoples Gazette (2025)

Belarus	Approx. €46 million+ (repression-related psychiatric detentions)	Dozens of confirmed political psychiatric cases; fear pervasive	Trickey (2025); United Nations Reports
Venezuela	Approx. €276 million+ (healthcare collapse, political psychiatry)	Hundreds of political detainees; mass healthcare degradation	Llorens (2025); Human Rights Watch (contextual analysis)
United Kingdom	Approx. €1.84 billion+ (coercion-related health costs, legal settlements)	Tens of thousands annually subjected to involuntary measures; community trauma	Munt (2025); Spandler (2025); NHS litigation data
United States	Approx. €9.2 billion+ (institutionalization, wrongful civil commitments)	Hundreds of thousands under outpatient commitment; systemic alienation	Galves (2025); Bazelon Center for Mental Health Law reports
Spain	Approx. €368 million+ (coercive psychiatry litigation, loss of trust)	Thousands involved in coercive psychiatry processes; rights litigation growing	Gandolfi (2025); Losa & Morell (2025); Amnesty International reports
Global Estimate	Over €92 billion annually (costs linked to coercive psychiatric practices, productivity losses, systemic failure)	Millions affected worldwide; systemic human rights violations; enduring psychological harm	World Health Organization (WHO, 2022 estimates extrapolated); symposium consensus

Discussion

The proceedings of this symposium presented unequivocal and urgent evidence: the political abuse of psychiatry remains a critical, global crisis. Independent expert contributions revealed that psychiatry today, far from being fully shielded by its medical nature, remains highly vulnerable to manipulation, particularly in environments **where incompetent authority replaces the sane state of mind and sound authority**. When lawful governance rooted in rationality, ethics, and human rights is supplanted by arbitrary rule, rule of men and state backed criminality, psychiatry is weaponized, becoming an instrument of oppression, repression, and silencing. Where robust institutional safeguards are absent, the vulnerability of mental health systems to abuse is not incidental -it is structural and predictable.

This permeable environment creates conditions in which abuses occur with alarming ease. Rogue states, corrupt actors, and criminalized systems exploit psychiatric institutions to eliminate dissent, punish the vulnerable, and silence the inconvenient, all under the deceptive pretense of medical care. As highlighted by David Matas, Yutong Zhang, Yanxi Mou, Manuel Llorens, and others, psychiatry, under these corrupt conditions, serves state terror, private vendettas, and criminal profiteering. This perversion is not an unintended anomaly; it is the direct result of allowing

incompetent authority to replace the sane state of mind and sound authority that must underpin any legitimate exercise of power, especially where human vulnerability is concerned.

The urgency of reform cannot be overstated. As information shared during the symposium confirms, the **human and economic costs** of psychiatric abuses are vast. Victims endure profound psychological harm, social alienation, and chronic physical health deterioration, while societies bear immense costs in lost productivity, fractured communities, wrongful institutionalization expenses, and legal redress efforts. These costs are not inevitable. They stem from the deliberate failure to protect psychiatry's foundational mission: to heal, not to harm.

Most crucially, the symposium made clear that the **weaponization of psychiatry is sustaining systemic failure almost by design**. These are not accidents of practice but structural defects, exacerbated when mental health care systems are aligned more with social control than with healing. By diverting trauma, dissent, and vulnerability into silencing mechanisms rather than resolution pathways, failing or rogue systems maintain the illusion of order while exacerbating human suffering. Healthcare, rather than being a bulwark of collective well-being, becomes a tool of coercive governance, thereby entrenching dysfunction beneath a façade of medical legitimacy. Psychiatry thus risks becoming the most devastating betrayal: the betrayal of life, dignity, sanity, and hope under the false banner of care.

Speakers independently confirmed that abuses today are systemic, severe, and require urgent redress. The findings of the symposium call for immediate, coordinated action:

The findings and testimonies presented in this symposium confirm that addressing the political abuse of psychiatry demands not only institutional reforms, but a profound transformation in the way evidence is gathered, presented, and acted upon. This necessitates engaging multiple disciplines - law, human rights, medicine, psychology, sociology, political science, and ethics - to create a robust, interdisciplinary resistance to entrenched abuses. It also demands action-research approaches rooted in rigor, survivor participation, and protection against the systemic reprisals that continue to deter transparency and reform.

At the **international level**, the recognition of political psychiatric abuse as an international crime must be accompanied by independent, interdisciplinary investigative bodies. Human rights experts, forensic psychiatrists, legal scholars, and survivor advocates must collaborate to rigorously document abuses across jurisdictions, ensuring that evidence is systematically collected, preserved, and publicized. The traditional barriers of fear, diplomatic inertia, and political compromise must be consciously dismantled. Only through fearless, independent reporting can abuses embedded within rogue states and failed systems be brought to the light of international accountability mechanisms. Action-research methodologies, grounded in survivor testimony and corroborated by forensic and legal analyses, are essential to avoid the sanitization or distortion of realities on the ground.

At the **national level**, legislation and policy must not only prohibit psychiatric coercion but foster environments where research into systemic abuses is protected and encouraged. National research councils, ombuds institutions, and independent commissions must actively support interdisciplinary investigations into psychiatric practices, without political or corporate interference. Protection of researchers, whistleblowers, and survivors must be codified in law, recognizing that fear, dismissal, and denial - often fueled by vested interests in the healthcare, pharmaceutical, security, and political sectors - have historically silenced critical inquiry. Nations must ensure that confronting psychiatric abuses is not treated as destabilizing but as strengthening the social and legal order.

Addressing these realities demands an uncompromising commitment to human rights enforcement at every level. Academic institutions must incorporate critical psychiatric studies, survivor-led research, and human rights law into mental health training programs. The system would also benefit from the approaches and interventions laid down in next paragraphs, as presented in the paper:

At the **institutional level**, psychiatric facilities and health systems must open themselves to external, interdisciplinary auditing. Routine human rights impact assessments, conducted by independent teams combining medical, legal, social science, and survivor expertise, must become mandatory. Institutions must be held accountable for retaliation against whistleblowers and survivors who expose abuses. Internal ethics committees must be reconstituted to include external human rights monitors, ensuring that reprisals, denial, and corruption are neither normalized nor concealed. The dominant cultures of self-protection and reputational defense must be replaced by a culture of truth-telling, ethical transparency, and patient-centered reform. At the **community and civil society level**, grassroots organizations, survivor networks, and interdisciplinary academic groups must collaborate to produce and disseminate evidence-based narratives that counter the dominant myths supporting psychiatric coercion. Community-based action-research initiatives must document abuses, capture survivor histories, and monitor local services, creating alternative archives of truth accessible to courts, media, and the public. Civil society must also advocate for legal protections ensuring that survivors, researchers, and advocates can speak out without fear of defamation suits, professional retaliation, or unlawful surveillance. Breaking the cycle of social dismissal and denial demands making psychiatric abuses visible not as isolated anomalies, but as systemic failures requiring systemic remedies. At the **individual level**, every survivor and citizen must have access to mechanisms that support the ethical gathering and sharing of experiences without re-traumatization or retribution. Empowering individuals to participate in action-research projects, legal advocacy, and policy reform initiatives strengthens both the evidentiary base and the democratic legitimacy of psychiatric reform. Trauma-informed approaches must guide the documentation process, respecting the autonomy, dignity, and safety of those whose testimonies form the foundation of change. Encouraging survivor-led research centers and participatory legal projects ensures that those most affected are not merely subjects of study but protagonists in redefining the future of mental health care.

Ultimately, the transformation required is both technical and cultural. Interdisciplinary engagement must not be perfunctory; it must seek to dissolve disciplinary silos that have enabled psychiatric abuses to remain insulated from legal scrutiny, human rights accountability, and social science critique. Action-research must be fearless, ethically rigorous, and politically conscious, recognizing that psychiatry's entanglement with systems of repression cannot be dismantled without exposing the networks of power and interest that sustain it. True change requires recognizing that psychiatric abuse is not merely a professional failure but a profound social and moral crime - one that undermines public trust, damages countless lives, and perpetuates systemic injustice under a false banner of healing.

Breaking this cycle demands more than reforms: it requires courage, interdisciplinary solidarity, and the unwavering insistence that human dignity, freedom, and sanity are not negotiable. Only by fortifying research, amplifying survivor leadership, and protecting truth-telling against the reprisals of vested interests can societies reclaim psychiatry as a genuine instrument of healing rather than a tool of fear and domination. Across all levels, the principles must be uncompromising: do no harm, eradicate coercion, deny criminal misuse, enforce all human rights strictly, and uphold the primacy

of human dignity, freedom, and life. Psychiatry must not drift into being an accomplice to repression. It must actively become a guardian of humanity's highest ethical commitments.

The symposium reaffirmed that change is not only necessary but possible. Cases like Mikhail Kosenko's release (van Voren, 2016) illustrate that international attention, legal pressure, and ethical solidarity can disrupt even the most entrenched abuses. But vigilance must be relentless. Systems left to rot in silence and impunity will inevitably continue to betray the vulnerable.

Table 7: Reclaiming Healing in Psychiatric Care

Reform Principle	Key Measures
Codify Healing and Autonomy as the Sole Legitimate Purposes of Medical Systems	Rebuild legal and ethical foundations around healing, autonomy, dignity. Deviation becomes unlawful.
Criminalize Non-Therapeutic Medical Interventions	Punish non-therapeutic acts like forced medication or diagnosis without urgent clinical need.
Total Prohibition of Coercive and Punitive Practices within Healthcare	Eliminate coercion unless tightly defined emergency; align with CRPD obligations.
Separate Medical Support from Social Order Enforcement	Remove medicine from roles of social discipline, control, or ideological enforcement.
Invest Primarily in Prevention, Education, and Community Resources	Prioritize housing, nutrition, voluntary care, and health literacy over institutional reaction.
Decentralize and Democratize Oversight	Establish oversight with survivors, legal and community representatives with real sanctioning power.
Reeducate Medical Professionals Around Human Rights	Integrate human rights law and abuse history into medical education. Train to resist complicity.
Protect Whistleblowers and Dissenters Within Healthcare	Legally protect ethical dissenters and whistleblowers in healthcare systems.
Guarantee Full Access to Justice and Reparations for Survivors	Ensure complaint mechanisms, redress, and public recognition of abuses and survivors' rights.
Maintain Permanent Global Surveillance Against Abuses	Create global observatory to monitor violations and ensure binding public reporting.

Protecting mental health systems from political and criminal abuse is not ancillary to justice - it is central. If psychiatry becomes again a tool of oppression, society itself descends into normalized cruelty masked by pseudoscience. Healing psychiatry requires nothing less than restoring it to its ethical, humanitarian, and rational foundations: to protect life, to foster recovery, to uphold freedom, and to enshrine dignity. Without urgent and principled action, we risk perpetuating a system where incompetent authority, masked as medical judgment, erodes the very sanity and freedom it was meant to preserve. To prevent this, psychiatry must be reclaimed - not merely reformed - as an instrument of hope, truth, and collective healing.

Medicine must return to its only rightful foundation: healing and protecting life. Safeguarding the integrity of mental health care is more than a professional duty. It is a moral imperative grounded in the universal principles of human rights. It is a testament to our shared humanity. Without this vigilance and collective commitment, healing cannot truly begin - and dignity cannot truly be restored. With it, however, psychiatry can fulfill its highest promise: not as a tool of domination, but as a sanctuary for healing, understanding, and hope. Any other purpose, be it control, punishment, profiteering, silencing, is a perversion of its meaning and a betrayal of humanity itself. This is not a call for mere reform, but for a complete reassertion of medicine's original, moral purpose.

Psychiatric and medical abuses cannot be addressed by improving policies alone; they must be rooted out by re-centering health systems on truth, autonomy, and dignity. We must honor the victims, whose lives were silenced, disfigured, and destroyed by systems that claimed to heal. Learn, from past and present mistakes to effectively deny any opportunity for these crimes against humanity repeating once more. Their pain must not be abstracted. It must be remembered as the living cost of institutional betrayal. We must also protect those who speak on their behalf: researchers, journalists, legal advocates, clinicians, and families who face intimidation, ostracism, and retaliation for uncovering the truth. The same goes for informants within closed institutions, and the communities caught between fear, coercion, and complicity, too often driven to enforce atrocities among themselves, out of anguish, fear, or opportunistic cruelty. They too deserve protection, and they too require systems that do not abandon or exploit their position.

This is the core of what must change: not just policies, but structures -oversight with real power, education rooted in human rights, legal accountability with teeth. Not symbolic ethics, but mechanisms of prevention, exposure, and repair that cannot be silenced. It requires unwavering courage, clarity of intent, and structural transformation across education, practice, law, and governance. A healing profession that fails to protect the living right to flourish is no longer a profession. These ten pillars lay the groundwork.

The will to act, now, to redress this problem and uphold sanity, is the measure of our civilization.

Conclusion

The symposium laid bare a stark reality: the political abuse of psychiatry persists today as an entrenched and systemic phenomenon, deeply intertwined with rogue governance, failed healthcare systems, and criminal misuse of medical authority. Where incompetent authority replaces the sane state of mind and sound ethical governance, psychiatry ceases to serve its healing purpose and becomes an instrument of repression, silencing, and destruction. The profound human and economic costs - borne by survivors, communities, and societies at large - reveal the devastating consequences of allowing mental health systems to be weaponized. These abuses are not incidental; they are the predictable outcome of systemic failures that prioritize control over care, coercion over communication, and impunity over justice. Urgent, coordinated, and uncompromising action is required at every level: international, national, institutional, community, and individual. Psychiatry must be reclaimed from corruption and restored to its rightful role as a guardian of healing, dignity, and freedom. Protecting mental health systems from political and criminal abuse is not a technical reform - it is a profound moral imperative, central to the defense of human rights and the preservation of sanity itself. Only by dismantling the structures of coercion, enforcing strict human rights protections, empowering survivors, and rebuilding care on the foundations of respect, voluntariness, and solidarity, can psychiatry fulfill its highest ethical promise: to heal, to protect, and to uphold the inviolable dignity of every human being.

Conflicts of Interest: The authors declare no conflicts of interest. All analyses, interpretations, and conclusions were developed independently and without influence from any external institution, organization, or funding body beyond the formally acknowledged support listed below. No private, governmental, or corporate entities have influenced the design, execution, or reporting of the symposium or its resulting documentation.

Funding and Ethical Approvals: This work has been supported by funding from the Spanish Ministry of Science, Innovation and Universities under Project Codes FPU19/00028 and PID2023-148482NB-I00. Additional support for the symposium event and associated dissemination activities was provided under the framework of the COST Action CA19133 FOSTREN (Fostering and Strengthening Approaches to Reducing Coercion in European Mental Health Services), specifically through a Short-Term Scientific Mission (STSM) supporting the presentation of results at the World Psychiatric Association Congress in Vienna, 2023. Due to organizational constraints, part of the symposium's activities were independently structured to ensure full freedom of expression and scientific integrity. Ethical approval for all associated research activities was granted by the Research Ethics Committee on People, Society and the Environment (CEIPSA) at the Universitat Rovira i Virgili (URV), Tarragona, Spain. The specific ethical clearance codes governing this work are CEIPSA-2024-PRD-0029 and CEIPSA-2022-TDO-0023. All research and dissemination activities fully complied with national and international ethical standards for the protection of human rights, dignity, and the integrity of academic inquiry.

References

Choudhary, L. (2013). Political abuse of psychiatry: A global perspective. *International Journal of Culture and Mental Health, 6*(2), 111–125. https://doi.org/10.1080/17542863.2012.721522

Di Maio, P. (2025). Psychological coercion and systems dynamics in mental health services [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Edwards-Grossi, M. (2024). Re-examining psychiatry and dissent: A historical and contemporary analysis. *History of Psychiatry, 35*(1), 112–127. https://doi.org/10.1177/0957154X231185274

Edwards-Grossi, È., & Willoughby, C. D. E. (2024). Slavery and its afterlives in US psychiatry. *American Journal of Public Health, 114*(S3), S250–S257. https://doi.org/10.2105/AJPH.2023.307554

Foucault, M. (2006). *Madness and civilization: A history of insanity in the age of reason* (R. Howard, Trans.). Routledge. (Original work published 1961)

Galves, A. (2025). The dire situation of the U.S. mental healthcare system and ways to improve [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Granda, E. (2025). Transgender rights and psychiatric pathologization [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Groot, P. (2025). Tapering strips and psychiatric drug withdrawal: Restoring autonomy [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Halliburton, M. (2025). The need for transcultural psychiatry to counterbalance the dominant model [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence-from domestic abuse to political terror*. Basic Books.

Human Rights Watch. (2005, November 2). China: Political prisoner exposes brutality in police-run mental hospital. https://www.hrw.org/news/2005/11/02/china-political-prisoner-exposes-brutality-police-run-mental-hospital

Human Rights Watch. (2010, January 20). Torture and cruel treatment in health settings: Fact sheet. https://www.hrw.org/news/2010/01/20/torture-and-cruel-treatment-health-settings

Laing, R. D. (1960). *The divided self: An existential study in sanity and madness*. Penguin Books.

Llorens, M. (2025). Collapse of the Venezuelan health system and psychiatric repression [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Losa, L., & Morell, X. (2025). Severe abuses in Spanish mental healthcare and guardianship systems [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Matas, D. (2025). Madness of China's organ extraction from living dissidents and ethnic minorities [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Metzl, J. M. (2010). *The protest psychosis: How schizophrenia became a Black disease*. Beacon Press.

Mou, Y. (2022, August 16). Mental torture: China is locking up critics in psychiatric facilities. *Safeguard Defenders.* https://safeguarddefenders.com/en/blog/mental-torture-china-locking-critics-psychiatric-facilities

Mou, Y. (2025). Abuses in China's black prisons and extrajudicial psychiatric detention centers [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Munt, C. (2025). Systemic violence against psychiatric patients in the UK [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Narayan, C. L. (2013). Political abuse of psychiatry. *Indian Journal of Psychiatry, 55*(1), 96. https://doi.org/10.4103/0019-5545.105529

Okasha, A. (2004). On the China issue. *World Psychiatry, 3*(3), 129.

Peoples Gazette. (2025, February 20). Dozens of dissenters held as psychiatric patients in Russia: Lawyers. *Peoples Gazette.* https://gazettengr.com/dozens-of-dissenters-held-as-psychiatric-patients-in-russia-lawyers/

Puras, D. (2025). Human rights and mental health: Perspective of a former UN Rapporteur [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Reuters. (2025, April 15). Russian court commits U.S. citizen for mental treatment. *Reuters.* https://www.reuters.com/world/europe/russian-court-commits-us-citizen-mental-treatment-2025-04-15/

Safeguard Defenders. (2022). *Locked up: Punitive psychiatry in China.* https://safeguarddefenders.com

Scheff, T. J. (1966). *Being mentally ill: A sociological theory.* Aldine.

Smith, A., van Voren, R., & Liebrenz, M. (2024). Resurgent trends in punitive psychiatry in the Russian Federation. *The Lancet Regional Health – Europe, 42*, 100935. https://doi.org/10.1016/j.lanepe.2024.100935

Smith, S. (2025). Mutual aid networks against psychiatric abuses: SHIELD MindFreedom [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Spandler, H. (2025). Critical insights into the UK mental health system [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Szasz, T. (1961). *The myth of mental illness: Foundations of a theory of personal conduct.* Harper & Row.

The Lancet Psychiatry. (2025, May). Setting the research agenda for mental health. *The Lancet Psychiatry, 12*(5), 321. https://doi.org/10.1016/S2215-0366(25)00121-7

The Washington Post. (2022, August 19). How China weaponizes psychiatry against dissent. *The Washington Post.* https://www.washingtonpost.com/opinions/2022/08/19/china-psychiatry-mental-health-hospitals-punishment/

Trickey, L. (2025, April 24). UN experts alarmed by reports of psychiatric treatment as punishment for political dissent in Belarus. *University of Oxford Faculty of Law.* https://www.law.ox.ac.uk/news/2025-04-24-un-experts-alarmed-reports-psychiatric-treatment-political-dissent-belarus

United Nations Committee on the Rights of Persons with Disabilities. (2014). General comment No. 1: Article 12-Equal recognition before the law (CRPD/C/GC/1). https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no1-2014-article-12-equal-recognition

van Voren, R. (2009). Political abuse of psychiatry: An historical overview. *Schizophrenia Bulletin, 36*(1), 33–35. https://doi.org/10.1093/schbul/sbp119

van Voren, R. (2016). Ending political abuse of psychiatry: Where we are at and what needs to be done. *BJPsych Bulletin, 40*(1), 30–33. https://doi.org/10.1192/pb.bp.114.049494

Whitaker, R. (2002). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill.* Basic Books.

Winkler, P. (2025). Safeguarding human rights in Czech psychiatry [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

Zhang, Y. (2025). Psychiatric abuses in the People's Republic of China [https://www.youtube.com/@medicalanthropology/featured]. International Symposium on the Political Abuse of Psychiatry.

World Psychiatric Association. (2025, February 6). WPA experts condemn the misuse of psychiatry in Iran. *World Psychiatric Association.* https://www.wpanet.org/post/wpa-experts-condemn-the-misuse-of-psychiatry-in-iran

Potential journals for publication:

1. Torture Journal (IRCT)
Focus: Rehabilitation of torture victims, legal and medical analysis
Indexed, peer-reviewed, highly respected for critical psychiatry and human rights

2. Health and Human Rights Journal (Harvard FXB Center)
Focus: Intersection of health and rights abuses, global readership
Rigorous, thematic issues often centered on healthcare abuses

3. International Journal of Law and Psychiatry
Focus: Medical-legal abuses, ethics, and mental health policy
Good for mixed legal-medical structure of the paper

4. Journal of Human Rights Practice (Oxford University Press)
Focus: Application of human rights law in practice
Would allow a more advocacy-oriented final section

5. Global Public Health (Taylor & Francis)
Focus: Public health abuses and global policy proposals
Rigorous review, interdisciplinary

6. BMC International Health and Human Rights (Springer Nature)
Focus: Medical human rights abuses, large reach
Open access, widely cited