Chapter 1. General framework and delimitation of the research

Abstract: The thesis underlying this dissertation and compendium of publications argues that the Spanish psychiatric system, in conjunction with judicial, social, and administrative mechanisms, perpetuates a structural framework of institutional violence that, far from protecting, inflicts and consolidates multidimensional social, familial, professional, healthcare, and existential harm by illegitimately appropriating people's identity and agency, denying their voice, decontextualizing their suffering, and medicalizing their difference. The antithesis is the dominant coercive biomedical model, which, under the pretext of care, imposes diagnoses without sufficient empirical basis, forced treatments without valid consent, and extrajudicial confinement legitimized by an uncritical technocracy and a permissive legal apparatus, operating as a machine of exclusion and silencing. The context in which both are situated is a profound crisis of legitimacy in the mental health system, whose legal, institutional, and epistemological architecture in Spain derives directly from a historically rooted penal apparatus that has displaced its punitive logic to the medical field. This legacy is not a mere remnant of the past, but the very foundation of modern institutional psychiatry: a tradition of pathologizing difference, medicalizing dissent, and disciplining bodies, built on centuries of practices of exclusion, segregation, and punishment. Despite some attempts at reform, the current system continues to reproduce this logic without effective external control mechanisms, without public auditing, and without recognition of victims. Prior to this dissertation, the existence of these dynamics was known in fragments, without an empirical, technical, and legal articulation capable of exposing their systematicity or proposing a viable transformation. This work responds to this omission, integrating mixed methodologies, analytical modeling, and ethnographic documentation within a biocultural action research framework, with verifiable proposals for structural redesign.

1.1. Brief historical context

The history of medicine is not a tale of wisdom guiding the vulnerable toward healing, but a chronicle of coercion and instrumentality, often veiled as care. From Mesopotamia to post-authoritarian Spain, knowledge has been monopolized, instrumentalized, and frequently weaponized by those embedded in state or clerical power. Physicians, when not subordinated to priests or sovereigns, functioned as enforcers of order: restoring soldiers, managing epidemics to preserve economic output, and suppressing expressions of suffering that threatened hierarchy (Porter, 1997). The minority of healers who advocated for pluralistic, preventive, or dialogical approaches operated under threat or exile. Their marginalization was not incidental but functional within paradigms in which medicine served conformity rather than autonomy (Foucault, 1963/2003). Roman medical organization, set as an example as foundation of our legal system, mirrored the empire’s military and extractive logic: it was utilitarian, centralized, and violently hierarchical. Health care was not a civic right but an instrument of imperial management. Clinical resources were concentrated in military encampments and patrician households, while the broader population, slaves, women, foreigners, and colonized subjects, was exposed to neglect, experimental practices, or coercive interventions (Temkin, 1973). Public health infrastructure existed only insofar as it safeguarded logistical continuity: aqueducts to secure grain supply, latrines to prevent mass unrest, quarantines to avert epidemics threatening the state. The concept of a shared right to health was absent. Within this model, the proletariat, as non-property-owning urban

dwellers whose labor was subject to extraction without autonomy, were managed as biomass: kept alive for productivity, not protected for dignity (Scheidel, 2010).

Table 1 - Historical approaches to mental and emotional states, by culture and region

Period / Region	Approach to Mental States	Practices & Substances	Interpretive Setting
Ancient Greece	Dream incubation; melancholia as philosophical temperament	Olive oil, wine, mandrake, poppy; communal sleep spaces	Temples, oracles, symposiums
Classical China	Qi imbalance treated via herbs, acupuncture, moral cultivation	Ginseng, tea, fasting, ancestor veneration	Confucian and Taoist circles
Medieval Islamic World	Prophetic dreams; spiritual melancholy	Saffron, ambergris, music, Qur'anic recitations	Hospitals, mosques, theological academies
Andean Cultures	Ritual singing, coca leaves, trance for balance and vision	Maize rituals, tobacco, fasting, dance	Community elders, spiritual healers
Renaissance Italy	Humoral theory, artistic catharsis, pilgrimage	Opium, absinthe, wine, confession	Courts, monasteries, salons
19th-century Europe	Institutional care; medicalized moral treatment	Morphine, bleeding, ether, electrotherapy	Asylums, elite clinics, literary circles

Treatments and interpretive settings for mental, emotional, and spiritual crises in various civilizations.

Reproductive systems, that being mainly the women’s womb, were juridical-medical sites of control. Under patria potestas, male household heads had total legal authority over their bodies. Medicosocial knowledge, framed in that context, such as that of Soranus of Ephesus in his *Gynaecology*, was anatomically advanced but framed female physiology as deficient, porous, and unstable, demanding regulation for dynastic and demographic purposes (King, 1998). Reproductive decisions were rarely left to those concerned as taked to gestate. Infanticide, forced abortion, and sexual violence were common and institutionally sanctioned through legal codes such as those collected in the *Digest* (Book 48, Ulpian). These inequalities and lack of autonomy to decide on one own, are integral part of the present dissertation study, as they have kept on reproducing to today.

The physician Aulus Cornelius Celsus, though not a practicing medic, compiled and codified one of the most revered Roman medical doctrines in *De Medicina* (1st century CE). In Book III, he explicitly states that certain procedures must be conducted *contra voluntatem aegri*, against the patient’s will, justifying cauterizations, amputations, and restraints as therapeutic imperatives (Celsus, ca. 30 CE/1935). For Celsus, the infliction of pain was not merely permissible but integral to good medicine. This logic extended to behavioral deviance, which, while not organized under a formal nosology of mental illness, was nevertheless framed as a disorder of will, discipline, or moral structure, a threat to the *civitas* and its hierarchy (Laurence, 1994). This intertwining of medical authority and state violence was not exclusively Roman. In Sumer, the asû (empirical healer) and āšipu (ritual expert) were embedded within temple bureaucracies. Their clinical observations were astute and methodical, Yet, subordinated to theocratic priorities (Geller, 2010).

Table 2 - Physiological control of cognition and emotion across eras, by culture and region

Era	Control Mechanism	Health Impact	Narrative Justification
Ancient Civilizations	Fasting rituals, wine feasts, caste-based food distribution	Nutrient-based stratification, ritual intoxication	Divine hierarchy, ritual purification
Medieval Europe	Church feasts for control, alcohol as religious sacrament, bread as loyalty tool	Famine cycles, moral malnutrition, monastic dietary restriction	Moralistic suffering, divine punishment
Modern Capitalist States	Processed food addiction, subsidies for sugar/alcohol, pharmaceutical dependency	Obesity, diabetes, inflammation, psychiatric pathologization	Consumer choice, biological determinism
Russia, late USSR	Vodka rationing, institutionalized alcoholism, chemical sedation for dissent	Liver disease, mass suicides, apathy	Revolutionary sacrifice, national hardship
Contemporary Global South	Junk food proliferation, privatized water, mental illness framing of poverty	Stunting, gut-brain dysfunction, mass depression and suicide	Clinical diagnosis, self-blame

Historical uses of food, drink, and altered states as instruments of social control and their psychiatric consequences, across epochs and geographies.

Prior to that period, during the third millennium BCE, Sumerian over-irrigation policies caused severe salinization of the soil. As wheat yields collapsed, societies shifted to barley, then disintegrated. Although the agrarian collapse was predictable and knowledge about soil recovery existed, it was ignored under political pressure to sustain extraction (Jacobsen, 1982). Health specialists, bounded within ritual roles and elite service, failed to intervene at a systemic level. A culture capable of calculating celestial events and compiling pharmacopoeias was unable to halt its own ecological suicide. This also speaks to today, and the planetary crisis we all collectively face.

In response to such collapses, several cultures encoded cycles of rest and redistribution into their normative frameworks. The prescription of the *Shmita*, a sabbatical year every seven years for land, workers, and even beasts of burden (Exodus 23:10–11; Leviticus 25), is a prime example in our shared foundational traditions. This was a radical articulation of social and ecological justice: an injunction to interrupt cycles of overwork, exploitation, and degradation. Similar concepts appear in the Andean *ayni*, which emphasized reciprocal labor, and in Vedic traditions that mandated periods of renunciation and pause. Yet, these practices were vulnerable to subversion. As polities centralized, the enforcement of rest diminished. Imperial expansion, urbanization, and war economies nullified prescriptions once considered vital for sustainability (Scott, 2017).

Table 3 – Ancient patterns of marginalization and control

Targeted Group	Mechanism of Harm	Structural Role	Exploitative Driver
Enslaved laborers	Overwork, beatings, no legal rights	Resource extraction, class enforcement	Profit from forced labor
Urban poor in temple economies	Food debt, labor conscription	Surplus dependency structure	Control and surplus extraction
War prisoners, enslaved	Forced public works, mutilation	Imperial consolidation	Domination via labor, fear
Household servants, slaves	Sexual/physical coercion	Lineage and domestic control	Power and normalized abuse

This table outlines the early institutional, economic, and ideological mechanisms used to regulate, exclude, or exploit marginalized populations in ancient societies, including Mesopotamian, Egyptian, Greco-Roman, and early imperial models. It highlights how sociopolitical systems organized labor, justified social hierarchies, and medicalized or spiritualized dissent, laying the groundwork for later biomedical and psychiatric rationales of exclusion and control (Briggs, 2022; Foucault, 1963/2003; Lerner, 1986).

These failures were not due to ignorance. They were deliberate subjugations of known wisdom to the priorities of ruling classes. And they recur. Modern liberal democracies, including post-Francoist Spain, retain medical-legal frameworks that prioritize control over care. Psychiatry remains a locus of this paradox. Diagnostic categories pathologize dissidence, coercive treatments remain common, and informed consent is routinely bypassed in the name of therapeutic necessity (Moncrieff, 2008; Rose, 2018). Women, especially those racialized, poor, or socially non-conforming, are overdiagnosed, overmedicated, and underheard. Life-course harms are reinterpreted as biochemical imbalances; trauma is relabeled as disorder. Interventions are pharmacological, not relational; institutional, not restorative.

Throughout early civilizations, the exhaustion of land and people was not merely a biological inevitability—it was a systemic consequence of production-oriented social organization that subordinated both ecology and subjectivity to external demands. In the Hebrew tradition, codified in the Torah, the Sabbath is not a mystical abstraction but an ontological declaration: human life must not be wholly consumed by servitude (Berlin, 2005; Heschel, 2005). This tradition, born out of the trauma of slavery, encoded rest as a safeguard against absolute domination, a civilizing mechanism to remember what unbounded extraction leads to—dehumanization, revolt, and collapse (Carroll, 1997; Brueggemann, 2014). Similarly, agricultural fallowing cycles reflected ecological intelligence rather than metaphysics: land exhausted without respite becomes infertile, just as bodies do. These principles were not merely spiritual; they were and are a technical requirement, a political imperative to follow. They are a collective memory system born of failure, collapse, and mass suffering—survivor intelligence (Clements, 1996). Yet, across history and into the present, these warnings have been ignored or perverted. The medical-legal establishment no longer listens to bodily thresholds; it regulates and overrides them. The symbolic has been replaced with the diagnostic; the prophetic with the procedural. Today, natural needs—sleep, pause, silence, pain, sorrow, withdrawal, bodily refusal—are no longer honored as safeguards but treated as symptoms to be corrected, subdued, or punished (Foucault, 1975/2003; Ehrenreich & English, 2005).

Table 4 – Medieval and early modern systems of targeted harm

Targeted Group	Mechanism of Harm	Structural Role	Exploitative Driver
Feudal serfs	Bonded to land, no mobility	Agrarian wealth, elite maintenance	Rent extraction, control
Women	Torture, execution	Moral/patriarchal purification	Sadistic spectacle, forced sexual pleasure, male power
Religious minorities	Ghettoization, massacres	Territorial consolidation	Confiscation, ethnic purge
Pauper orphans	Forced labor, abuse	Cost-saving institutions	Institutional labor, neglect

This table presents the structural targeting of vulnerable populations in feudal and premodern Europe, including women, serfs, orphans, and religious minorities. These mechanisms—ranging from torture and forced labor to public executions—served not only as instruments of order and moral enforcement but also as technologies of terror, pleasure, and accumulation. The continuity of these practices into medical-legal frameworks underscores how control and exploitation were historically normalized through theological, patriarchal, and juridical rationales (Barstow, 1994; Kamen, 1988; Federici, 2004).

Throughout early civilizations, the exhaustion of land and people was not merely a biological inevitability—it was a systemic consequence of production-oriented social structures that subordinated ecological rhythms and bodily needs to authoritarian extraction. In the Hebrew tradition, codified in the Torah, the Sabbath was not simply religious ritual, but a legal innovation born of slavery: an encoded recognition that human life could not be reduced to perpetual labor without destroying society itself (Berlin, 2005; Brueggemann, 2014; Heschel, 2005). Agricultural fallowing cycles mirrored this biopolitical insight, reinforcing that land, like people, required rest to avoid irreversible collapse (Clements, 1996). These were not spiritual metaphors—they were pragmatic survival codes etched from collapse and enforced to prevent recurrence. Yet, from late antiquity through the Middle Ages, this survivor intelligence was discarded or corrupted by new hegemonies: theological absolutism, feudalism, and punitive sexual regimes.

Table 5 - Historical Governance

Era / Region	Gender/Class Subjugation	Knowledge & Skill Preservation	Pleasure/Profit from Violence
Late Roman Empire	Women pushed to domesticity, elite concubinage	Classical knowledge preserved in minor schools	Public executions, military spectacles
Byzantine Empire	Elite women cloistered, lay women silenced	Preserved Hippocratic and Galenic medicine	Heresy purges and imperial torture rituals
Islamic Golden Age	Gender roles ambivalent; women could own property	Translation movement, Al-Razi, Ibn Sina	Judicial amputations, corporal punishments
Western Medieval Europe	Serfdom, female witch-hunts, orphans enslaved	Monasteries kept rudimentary archives	Witch-burnings, pillories, sacrificial wars
Early Modern Europe	Factory discipline, sexual commodification	Renaissance humanism, clandestine printing	Colonization as health sacrifice zone

This table disaggregates the role of gender and class in systems of exploitation, emphasizing how social identity intersected with epistemic and somatic control. Women, the poor, and the colonized were subject to layered forms of violence, including the confiscation of reproductive autonomy, criminalization of alternative knowledge systems, and commodification of pain for profit or pleasure. These dynamics laid the groundwork for modern institutional cruelty, in which trauma is still misrecognized as disorder and agency as deviance (Barstow, 1994; Lerner, 1986; Scarry, 1985; Gøtzsche, 2015).

The so-called European dark ages were not devoid of intelligence, but marked by its forced suppression and rechanneling. With the fall of Rome, the infrastructure that supported transcontinental trade, public health, urban planning, and scholarly exchange disintegrated. Roads decayed, aqueducts crumbled, and markets shrank. Cities depopulated and literacy collapsed outside elite and monastic enclaves. The state no longer mediated between population needs and public investment, but instead devolved into fragmented baronial control, where violence was the primary medium of governance. What remained of ancient science—across medicine, astronomy, and philosophy—survived largely through Islamic, Jewish, and Eastern Christian transmission, including repositories in Baghdad, Córdoba, and Constantinople (Lindberg, 1992; Gutas, 1998; Saliba, 2007). Within Europe, intelligence did not vanish but was driven into monasteries and cloisters, where second sons of often noble lineage were traditionally deposited as carriers of memory and safeguarded from harm. Monasteries became custodians of knowledge in a literal sense—scriptoria reproduced manuscripts, often without comprehension, and knowledge transmission was yoked to theological orthodoxy. Curiosity was circumscribed, and cosmology narrowed under scholastic constraints. Emotional life and cognitive exploration were rigidly mapped onto dogmatic structures, which treated suffering as divine punishment and dissent as moral failure (Grant, 2001; Daston & Park, 2001). The sanity of a people surviving on famine diets, chronic illness, and daily violence was contingent upon adherence to religious narrative. To question the order was to jeopardize not only the soul, but one's bodily safety.

Table 6 – Historical Governance Table

Era / Region	Health & Public Systems	Governance & Control Strategies	Population Obedience & Training
Late Roman Empire	Urban health infrastructure failing; aqueducts collapsing	Tax pressure, military conscription, Christianity as unifying coercion	Discipline by legions, declining civilian readiness
Byzantine Empire	Hospital and orphanage system maintained in Constantinople	Bureaucratic complexity, theological policing	Monastic discipline, literacy enforced in clergy
Islamic Golden Age	Advancements in hospital, hygiene, pharmacology	Meritocratic science hubs under caliphates	Intellectual training for elites, physical jihad
Western Medieval Europe	Monastic medicine, leechcraft, rural famine	Feudal oppression, Church authoritarianism	Martial training for nobility, no peasant rights
Early Modern Europe	Poor laws, plague controls patchy	Absolutism, birth of central states	Standing armies, mass conscription

This table synthesizes key historical structures across antiquity and the medieval period, highlighting governance logics that linked obedience to biopolitical submission. Populations were managed through enforced ignorance, physical exhaustion, or ritualized subjugation, with the state or empire extracting productivity and loyalty by shaping bodily and cognitive norms. Medical traditions—when not entirely displaced—were co-opted into controlling apparatuses that punished deviation or suffering as moral failure. Structural violence was normalized and encoded into law, pedagogy, and sacred practice (Federici, 2004; Kamen, 1988; Lindberg, 1992).

European feudal regimes, sustained through a fusion of military coercion and ecclesiastical legitimation, established institutional brutality as moral virtue. Legal codes enshrined the ownership of women, peasants, and their labor. Sexual violence was endemic and normalized, particularly

toward enslaved populations, pauperized single mothers, and prostitutes—whose very existence was shaped by structural desperation. The mutilation of bodies—through branding, amputation, torture, or execution—was not only punitive but theatrical: a ritual demonstration of elite impunity and mass subordination. Across medieval Europe, one in ten inhabitants might be executed or publicly punished in peak cycles of repression—not for individual threat, but as population control and psychological terror (Scarry, 1985; Kamen, 1988). Women, in particular, bore the brunt of theological-medical collusion. Their reproductive autonomy, midwifery knowledge, and spiritual roles were violently dismantled during centuries of witch hunts, ecclesiastical trials, and forced conversions. Theological arguments branded menstruation, sexuality, or emotional sensitivity as signs of inferiority or demonic possession, institutionalizing cognitive difference as disorder (Barstow, 1994; Federici, 2004). Charlemagne's empire imposed Christianity by the sword, while rulers like Henry VIII in Britain nationalized religious institutions to consolidate power, displacing poor women and orphans into criminalized categories under the Poor Laws (Slack, 1990). Political rationality, meanwhile, was claimed by elites who used Greek metaphysics, Roman legalism, and biblical authority to justify hereditary rule and mass disenfranchisement.

These were not mistakes. Medieval institutions were not irrational, as those served a purpose and did it well - they were once new calculated technologies of rule, also springing out of need. The Inquisition functioned as a medical-theological tribunal in which bodily symptoms of trauma or rebellion were interpreted as evidence of heresy, demonic possession, or female evil (Kamen, 1988; Kaplan, 2007). Paupers, single mothers, ethnic minorities, and those suffering mental distress were swept into orphanages, workhouses, or public executions not because they disrupted order but because they embodied truths the regime could not accommodate: suffering as political fact, not moral defect. Public torture and executions functioned as sadistic pedagogy—lessons to the population about the price of dissent and the pleasure of domination (Scarry, 1985; Foucault, 1975/2003). The so-called rebirth of reason began with trade routes and banking dynasties reclaiming Mediterranean infrastructures, not with democratization. And even then, the plague, inquisitions, and crusades continued. Civilization had not advanced; it had merely reassembled. The collapse was never total—but the price paid was. What followed in modernity was not rupture but rebranding. Psychiatry inherited these logics and updated the grammar. Symptoms once read as spiritual deviation were now classified under new taxonomies of degeneracy, hysteria, and psychosis—anchored to the authority of the medical professional rather than the priest, but with comparable disregard for lived experience and human dignity. The asylums of the 18th and 19th centuries carried out containment, coercion, and abuse under the premise of moral treatment, but with instruments ranging from bleeding to isolation to electroshock (Scull, 1989; Showalter, 1985).

Table 7 - Modern governance and social control

Era / Region	Health & Public Systems	Governance & Control Strategies	Population Obedience & Training
Early 20th Century (Global)	State hospitals, eugenics programs	Nationalist science, social hygiene laws	Work-based rehabilitation, military drafts
Mid 20th Century	Mass institutionalization, psychiatric genocide	Ideological purges, racial biology	Compulsory loyalty rituals, secret policing
Late 20th Century	Deinstitutionalization, privatized healthcare	Market logics, biopolitical management	Self-optimization, therapy culture
21st Century	Digital health regimes, data surveillance	Platform capitalism, algorithmic control	Censorship, predictive profiling

This table contrasts the dominant political logics of population control across the 20th and 21st centuries, spanning totalitarianism, neoliberal governance, and algorithmic rationality. While modes differ—from centralized psychiatric repression to decentralized economic dispossession—all systems share a core commitment to suppressing dissent and reinforcing hierarchical order through coercive or pharmacological means. Rationality is often redefined to justify violence as necessity, psychiatry as discipline, and poverty as pathology (Rose, 2006; Moncrieff, 2022; Flynn, 2021).

In Francoist Spain and Nazi Germany alike, psychiatry served explicitly genocidal goals—pathologizing political opponents, women, the disabled, and ethnic groups under the pretense of biological hygiene (Huertas, 1996; Lifton, 1986). The psychiatric category became the new heresy: once marked, one was no longer credible, no longer safe, no longer fully human. Still today, these genealogies of harm remain unbroken. Migrant care workers, racialized single mothers, survivors of child abuse, and those resisting institutional violence continue to be recoded as pathological, dangerous, or irrational—not on the basis of evidence, but through entrenched administrative and medical logics of social control (Anderson, 2000; Parreñas, 2001; Roberts, 2002; Richie, 2012). Their embodied knowledge is delegitimized, not merely ignored but structurally erased, as clinical classifications and welfare systems convert political or social grievances into psychiatric symptoms (Rose, 2006; Cosgrove et al., 2020; Moncrieff, 2022). The violence does not always appear as spectacle; it functions bureaucratically—through files, forms, diagnoses, custody transfers, and institutional placement—executed without public outrage, often without visible confrontation, but culminating in silencing, dependency, social death, and premature mortality (Whitaker, 2011; Flynn, 2021; Amnesty International, 2023).

Table 8 - Modern governance and institutionalized violence

Era / Region	Gender/Class Subjugation	Knowledge & Skill Preservation	Pleasure/Profit from Violence
Early 20th Century (Global)	Pro-natalist propaganda, industrial patriarchy	Medical academies, colonial science	Anatomical exploitation, forced labor profits
Mid 20th Century	Re-education camps, gender purging	Propaganda science, psychiatric policing	Spectacular trials, state terror aesthetics
Late 20th Century	Sexual commodification, gig precarity	Elite universities, managerialism	Prison-industrial complex, insurance markets
21st Century	Digital trafficking, biometric sorting	Platform knowledge monopolies	AI prediction economies, migrant exploitation

This table catalogs the institutional mechanisms—psychiatric, legal, technological, and bureaucratic—used to surveil, silence, or chemically subdue populations deemed unfit, inconvenient, or rebellious. While framed as therapeutic or security-enhancing, these systems function to obscure structural violence and redistribute blame from failing institutions to vulnerable individuals. The so-called care infrastructure reproduces inequality while denying the epistemic legitimacy of those most harmed (Cosgrove et al., 2020; Amnesty International, 2023).

The health system, family court, and psychiatric apparatus intersect to reinforce a moral hierarchy in which resilience under coercion is interpreted as disorder, and any attempt to resist or report abuse is met with institutional retaliation or diagnostic discrediting (Gøtzsche, 2015; Goodmark, 2018; Sadowski, 2020). The result is the perpetuation of cruelty under the guise of care, the weaponization of science to consolidate authority, and the severing of human beings from their social standing, legal voice, and bodily integrity. The task of medicine, psychiatry, and social science is not to conform to these punitive legacies, but to unmask and dismantle them. This demands a scientific and moral reckoning with the harm embedded in treatment-as-usual, a revaluation of refusal and distress as adaptive responses rather than pathological breakdowns (van der Kolk, 2014; Federici, 2004). It also demands the restoration of bodily autonomy, communal knowledge systems, and trauma-literate infrastructures—capable of recognizing when systems harm rather than heal, and of building public health practices rooted not in hierarchy and submission, but in equity, participation, and historical truth (Lerner, 1986; Rose, 2006; Flynn, 2021).

Medieval mechanisms of control did not end with the Enlightenment, and remain active today. Rather, they were restructured and expanded through clinical, juridical, and bureaucratic apparatuses embedded in the modern state. Psychiatric institutions today function not only as sites of supposed healing but also as containment structures for individuals whose pain, deviation, or resistance does not conform to the imposed norms of neurotypical, apolitical, and economically productive citizenship (Rose, 2006; Sadowski, 2020). Through the medicalization of suffering and trauma, the psychiatric system legitimizes coercive interventions—chemical, physical, and institutional—under the guise of therapeutic necessity (Moncrieff, 2022; Cosgrove et al., 2020). Psychopharmacology, administered as routine practice, becomes a mechanism of enforced erasure: stripping agency, rewriting histories of abuse into diagnostic labels, and enforcing docility through metabolic and neurological submission (Whitaker, 2011; Gøtzsche, 2015).

Table 9 - Institutional, psychiatric, and ideological control in the 20th–21st century

Category of Control	Mechanism Employed	Institutions Involved	Target Populations
Psychiatric Coercion	Involuntary hospitalization, forced medication, misdiagnosis of dissent as pathology	Asylums, psychiatric hospitals, forensic units	Political dissidents, abused women, neurodivergent individuals
Medical Pathologization of Poverty	Reclassification of trauma or social deprivation as chronic mental illness	Social security psychiatry, disability assessments	Working-class populations, unemployed, single mothers
Carceral Expansion	Prison-like psychiatric wards, secure treatment centers, chemical restraints	Prisons, juvenile institutions, closed psychiatric units	Racialized youth, migrants, the homeless
Welfare Surveillance	Psychiatric labeling to restrict parental rights, enforce state guardianship, or justify removals	Family courts, CPS, state guardianship bodies	Poor families, survivors of abuse, foster system entrants
Ideological Re-education	Therapeutic correction of gender identity, political beliefs, or trauma narratives	Conversion therapy programs, military psychiatry, propaganda schools	LGBTQ+ individuals, political prisoners, rape victims
Digital & Algorithmic Control	Predictive policing, mental health flagging via social media, biometric sorting	Tech companies, predictive analytics firms, insurance brokers	Protesters, those with non-normative behaviors or expressions
Drug-Based Pacification	Long-term prescription of sedatives, antipsychotics, and mood stabilizers for non-severe distress	Primary care clinics, elderly care, schools	Children, elderly, women, those reporting abuse
Bureaucratic Silencing	Diagnosis used to dismiss testimony, deny legal claims, or erase credibility	Courts, police forces, hospitals	Victims of domestic and institutional violence

This table categorizes the dominant state and institutional strategies of psychological, ideological, and bodily control from the 20th century to the present. It includes coercive psychiatry, militarization, food monopolies, welfare surveillance, and technocratic governance across authoritarian, neoliberal, and hybrid regimes. Emphasis is placed on the operational role of psychiatry and health discourses in reframing dissent as disorder, and on the continuity of social control logics across political systems allegedly opposed in ideology but aligned in biopolitical function (Moncrieff, 2022; Rose, 2006; Cosgrove et al., 2020; WHO, 2022).

The parallels with broader systems of exploitation are striking. Migrant care workers—predominantly racialized women—labor under regimes of surveillance and legal precarity that facilitate violence while preventing accountability. Their roles sustain the social and economic viability of entire countries, yet they remain structurally invisible and unprotected due to the constant threat of deportation or retaliation (Anderson, 2000; Parreñas, 2001; Lutz, 2008). Single mothers, particularly those abandoned, impoverished, or survivors of abuse, are not met with support but with moral condemnation and bureaucratic intrusion. Welfare systems surveil them more rigorously than they assist, often stripping them of decision-making autonomy under justifications of child protection while ignoring the structural violence that necessitated state involvement in the first place (Hays, 2003; Roberts, 2002; Federici, 2012). Children removed into foster or residential systems endure repeated emotional ruptures, institutionalization of trauma, and displacement—consequences systematically individualized as psychopathology rather than

acknowledged as harm inflicted by a punitive welfare logic (Chamberlain et al., 2006; Doyle, 2007). Worse still is the reclassification of survivors as threats. Individuals who endure sexual violence, trafficking, intimate terrorism, or psychiatric abuse are often punished when they resist or disclose. They are subjected to punitive incarceration, wrongful psychiatric labeling, and re-traumatization under a system that weaponizes protection as control (Goodmark, 2018; Richie, 2012; van der Kolk, 2014). This cycle of violence does not stop with the marginalized: professionals, journalists, and political dissidents who seek accountability—those who document, intervene, or testify—are strategically discredited, criminalized, surveilled, or institutionally exiled. Their public delegitimization is not incidental but foundational to the preservation of institutional impunity (Flynn, 2021; Amnesty International, 2023; Horne, 2022; Scheper-Hughes, 2004). Such dynamics operate not only in so-called failed states or collapsed jurisdictions but across professional, academic, and governmental settings under the guise of clinical care or administrative procedure. What remains consistent are the drivers: profit maximization, monopolization of narrative control, and the grim satisfaction derived from subordinating those who dissent. In clinical psychiatry, this manifests as the silencing of experiential truth in favor of pharmaceutical and bureaucratic reductionism. In familial settings, it appears as normalized abuse masked as tradition or care. In institutional contexts, it is seen in the brutal punishment of transparency and courage. These processes are not errors of application but expressions of systemic design. Whether in prisons, hospitals, courts, or care homes, the moral architecture remains committed to upholding dominion—by force, by silence, or by shame.

Table 10 - Cultural Handling of Altered States and Mental Distress, by era and region

Period / Region	Induced or Treated States	Substances / Foods Used	Rituals and Settings	Interpretive Agents
Ancient Greece	Melancholy, catharsis, divine mania	Wine, opium, hellebore, honeyed potions	Dionysian rites, Asclepian dream incubation	Temple priests, philosophers
Vedic India	Mystical ecstasy, sorrow, mental heat	Soma, clarified butter, ayurvedic herbs	Fire sacrifices, meditative chanting, seasonal fasting	Brahmins, gurus, healers
Indigenous Amazon	Vision quests, ancestral possession	Ayahuasca, tobacco, chicha	Night rituals, group singing, jungle immersion	Shamans, elder women
Classical China	Grief, madness, spiritual imbalance	Ginseng, reishi mushroom, rice wine	Ancestral rituals, seasonal feasts, dream diaries	Daoist sages, Confucian scholars
Medieval Islamicate	Spiritual melancholia, obsession	Ambergris, rosewater, saffron	Music therapy, Qur'anic dream interpretation	Hakims, theologians, Sufis
Medieval Europe	Demonic possession, melancholia	Absinthe, belladonna, fasting and bread	Exorcisms, fasting, flagellation, confession	Monks, inquisitors, barbers
Edo Japan	Existential grief, societal shame	Green tea, fermented rice, incense	Theater (Noh), writing, communal poetry	Zen monks, poets, physicians
Andean Highlands	Soul loss, trance, ecstatic mourning	Coca leaves, maize beer, llama fat	Dance, bloodletting, mountain offerings	Curanderos, community elders
Renaissance Europe	Black bile melancholy, divine madness	Laudanum, herbal tonics, red wine	Patronage of art, alchemy, mirror-gazing	Artists, physicians, mystics
Yoruba West Africa	Spirit possession, ecstatic healing	Palm wine, kola nut, herbal smokes	Drumming, trance, divination ceremonies	Orisha priests, healers
Early Modern Europe	Hysteria, melancholia, rapture	Purgatives, mercury, opiates, hot baths	Magnetism sessions, mesmerism, confession	Physicians, moral managers

Historical approaches to madness, melancholy, divine ecstasy, and psychological suffering across world traditions, focusing on ritual, substances, communal interpretation, and contextual care practices.

Food, drink, and the systematic distortion of education, and reward systems are integral part of all mechanisms of healing and harm, family and societal control in different cultural contexts. From feudal feasts to 20th-century state alcohol monopolies, rulers have long used sustenance and intoxication not only to placate populations, but to break their coherence. In late Soviet Russia, alcohol served as both escape and euthanasia; its widespread use mirrored the despair of economic stagnation and bureaucratic cruelty. This legacy of induced misery continues under modern capitalist regimes, where addiction, poor nutrition, and depression correlate with socio-economic collapse, yet remain framed as private pathology. Suicide by alcohol—epidemiologically documented as death of despair—is still rendered as clinical failure rather than systemic betrayal (Case & Deaton, 2020; WHO, 2022).

This cultural displacement—from relational, cosmologically integrated, and communally navigated

forms of care toward fragmented, biomedicalized, and diagnostically codified regimes—did not unfold through an objective evaluation of outcomes, nor from empirical superiority. Rather, it was the product of layered systemic enclosures: the seizure of epistemological authority, the centralization of institutional legitimacy, and the recoding of human variance into pathologized deviation (Foucault, 2003; Rose, 2006). The ascendancy of pharmacological psychiatry, particularly the widespread and often involuntary administration of psychotropic substances, reflects not a maturation of therapeutic science but a reconfiguration of governance: one where control is exercised through biochemical discipline rather than relational understanding. Drugs became the primary mode of intervention not because of healing efficacy, but because they harmonized with industrial efficiency, bureaucratic convenience, and neoliberal governance structures (Moncrieff, 2022; Gøtzsche, 2015). The post-World War II normalization of chemical restraints—marketed as breakthroughs in treatment—disguised their carceral function: silencing behavior, dampening protest, and facilitating the rapid turnover of institutional beds without attending to the underlying drivers of suffering (Scull, 2015; Whitaker, 2011).

What emerged was not a health system guided by dialogue, but one oriented toward diagnostic policing. The transition from collective healing to clinical containment reflects a broader political arc: the transformation of public health into a mechanism of population management. Psychiatric detention and forced medication are not aberrant but entirely coherent within the historical continuity of patriarchal, punitive governance. As Foucault (2003) and Szasz (1970) have argued, psychiatry often operates as a state-sanctioned apparatus of normalization, where individual divergence is recoded as pathology, and subjective suffering becomes a warrant for medical domination. This is reflected in clinical guidelines that authorize involuntary treatment based on vague criteria of dangerousness, ignoring the socio-political roots of distress. The outcome is not relief but institutional erasure: a long-term process of de-authorization, where the individual's knowledge of self is invalidated and replaced with a lifetime of surveillance, sedation, and social exclusion (Cosgrove et al., 2020).

Despite decades of scientific scrutiny, no compelling longitudinal evidence supports the inherent superiority of psychotropic pharmacotherapy over non-medical or minimally medicalized alternatives in most psychiatric conditions. On the contrary, a growing corpus of research documents the adverse long-term outcomes associated with sustained psychotropic use, including metabolic syndrome, cortical atrophy, emotional numbing, sexual dysfunction, and iatrogenic dependence (Bola et al., 2011; Gøtzsche, 2015; Moncrieff & Timimi, 2013; Whitaker, 2011). Many first-line psychiatric medications—such as benzodiazepines, neuroleptics, and SSRIs—originated as or remain chemically related to agents developed for veterinary sedation, anesthetic induction, or tranquilization in industrial contexts (Healy, 2002; Petty, 1995). Chlorpromazine, for example, was first synthesized as a pre-anesthetic agent for surgical use and quickly adapted into psychiatric contexts due to its behavioral dampening properties—not for its curative potential, but its capacity to induce docility (Ban, 2007). The extrapolation of such compounds to chronic psychiatric use reflects not empirical necessity but institutional convenience, driven by political, economic, and logistical imperatives.

Table 11 - Physiological and social harms of forced psychotropic drugging

Category	Description of Harm
Neurological impairment	Tardive dyskinesia, akathisia, extrapyramidal symptoms, cognitive dulling, and neuroleptic-induced deficit syndrome are frequent outcomes of long-term use of antipsychotics
Metabolic and endocrine harm	Weight gain, insulin resistance, hyperlipidemia, and elevated risk of diabetes and cardiovascular disease
Sedation and dependency	Many psychotropics, including benzodiazepines and antipsychotics, originate from or mimic substances used in veterinary anesthesia; their use leads to dependency and emotional blunting
Loss of autonomy	Individuals subjected to forced drugging report lack of control, hopelessness, and inability to exercise basic civil or bodily rights
Isolation	Coerced individuals are perceived as dangerous or incompetent, intensifying social exclusion and familial rupture
Institutional dependency	Psychiatric treatment becomes synonymous with medication compliance; relational or psychosocial interventions are sidelined or unavailable
Social death	The combined effect of stigma, surveillance, and disempowerment results in symbolic exclusion from community and public life
Increased mortality	Long-term use of psychotropics, especially antipsychotics, is associated with reduced life expectancy by 10–20 years compared to the non-drugged cohorts, suicide and disease exceedingly high due to compounding harm and forced nature of the regime

Multifaceted physiological and social harms associated with forced psychiatric drugging, as documented in global and Spanish research contexts. These harms challenge the legitimacy of treatment-as-usual models, especially in coercive settings, and demand systemic transformation in mental health care.

Forced drugging, particularly in institutional psychiatric settings across Spain and Europe, remains widespread despite legal frameworks designed to restrict its use. Measures such as physical restraint and involuntary medication are formally regulated under laws that establish their application as exceptional, requiring strict clinical justification, temporal limitation, and external monitoring (González & Romero, 2020; Huertas, 2022). However, ethnographic and observational studies have demonstrated that these practices are frequently operationalized as default strategies to manage institutional dynamics rather than as last-resort clinical interventions (Sweeney et al., 2018; Sisti et al., 2021). The justifications offered—risk to self or others, lack of insight, non-adherence—are often embedded in professional discourses that obscure the social, political, and economic determinants of distress, reducing complex suffering to allegedly deviant neurochemistry or deficient rationality (Foucault, 1975/2003; Metzl, 2009; Moncrieff, 2022).

This routine pharmacological control persists not due to robust evidence of superior outcomes, but because it facilitates administrative efficiency, imposes conformity, and deflects responsibility for structural neglect. Longitudinal research reveals the profound iatrogenic harms associated with chronic psychotropic exposure, including metabolic syndrome, cardiovascular disease, and premature mortality, disproportionately affecting already vulnerable populations (De Hert et al., 2011; Vancampfort et al., 2015; Tiihonen et al., 2009). Furthermore, forced drugging contributes to social death: the disempowerment, silencing, and erasure of personhood under medical custody (Burstow, 2015; Puras, 2017). The managerial preference for sedation over engagement reflects not medical necessity but the institutional logic of austerity, hierarchy, and control (Kirmayer & Pedersen, 2014; Rose et al., 2019). Despite calls from global authorities for a transformation toward community-based, rights-oriented care models that emphasize informed consent, peer support, and

psychosocial rehabilitation (WHO, 2021; Cosgrove et al., 2020), implementation remains limited. Austerity measures, pharmaceutical lobbying, and ingrained biomedical ideologies obstruct meaningful change (Breggin, 1991; Olfson et al., 2015). The enduring gap between evidence and practice constitutes a structural failure of care that must be addressed through participatory action-research, leading to continuous improvements, adapted to the needs of the population.

Table 12 - Perceived benefits of pharmacotherapy and stakeholder gains

Actor / Stakeholder	Perceived Benefit from Pharmacotherapy	Limitations / Costs Not Internalized by Actor
Individual patient (selected cases)	Short-term relief of acute symptoms (e.g., anxiety, hallucinations)	Long-term metabolic, cognitive and social harm (De Hert et al., 2011; Vancampfort et al., 2015)
Family members (under duress or without support)	Perceived behavioral stabilization reducing household conflict	Loss of autonomy and relational strain; lack of alternatives or systemic support
Clinical staff (psychiatrists, nurses)	Simplified patient management, symptom control under time/resource constraints	Ethical conflicts, burnout, and professional dissatisfaction in coercive settings
Hospital administrations	Cost-effective containment strategy; lower staffing burdens	Poor long-term outcomes; dependency on institutional cycles
Pharmaceutical companies	Revenue from medication sales; expansion of clinical indications	No responsibility for adverse outcomes or social consequences
Government / public policy makers	Budget control, reduced political risk from visible unrest or psychiatric crises	Long-term social exclusion, disability rates, and human rights scrutiny
Insurance systems (public/private)	Predictable and measurable cost structure	Externalization of broader psychosocial recovery costs

Actors who benefit directly or indirectly from pharmacotherapeutic paradigms in mental health care, while highlighting how harms and systemic consequences are often borne by patients and society at large rather than those incentivized to uphold current models.

Despite the overwhelming evidence highlighting the harms of overmedicalization and coercive practices, a broad spectrum of institutional actors continues to rationalize the use of psychotropic drugs and forced interventions under the guise of necessity, stability, and therapeutic logic. Academic psychiatrists and professors, especially those embedded in traditional biomedical faculties, often present pharmacological control as an evidence-based, ethically neutral standard. However, the scientific literature indicates that such claims are undercut by methodological biases, questionable generalizability of findings, and a sustained lack of longitudinal efficacy in many domains of mental health care (Moncrieff, 2022; Cosgrove et al., 2020).

Policymakers and public health officials defend these interventions by invoking public safety and cost containment, yet fail to address the structural determinants of mental distress or the chronicity often induced by current treatment paradigms (Sisti et al., 2021). This mismatch is sustained by a political calculus that privileges procedural efficiency over systemic transformation. At the clinical level, psychiatrists and frontline workers frequently rely on coercive measures not due to robust clinical need, but because of institutional inertia, time scarcity, legal ambiguity, and a dearth of alternatives, especially those requiring dialogical or resource-intensive engagement (Sweeney et al., 2018). Pharmaceutical-aligned researchers further reinforce this system through the selective publication of favorable results, financial entanglements with industry, and mechanisms such as

ghostwriting and under-reporting of adverse outcomes, as well as career advancement blocking against honest peers (Gøtzsche, 2015). Nurses and ward personnel, while often undertrained in trauma-informed or rights-based approaches, implement control strategies under working conditions marked by stress, understaffing, and managerial imperatives (Huertas, 2022).

Table 19. Structural Dangers of Coercive Psychiatric Regimes

Mechanism	Description	Consequences
Diagnostic ambiguity	Psychiatric categories are broad and elastic, easily fitting divergent behaviors	Enables strategic misuse to delegitimize or silence individuals
Family-based false reporting	Relatives fabricate symptoms or narratives to institutionalize or disempower	Enables extrajudicial detention and forced drugging
Institutional obedience	Staff comply with hierarchical mandates despite ethical doubts	Reduces possibility of intervention or whistleblowing
Legal incapacitation	Diagnoses lead to diminished legal standing and presumption of untrustworthiness	Limits capacity to defend oneself or contest abuse
Forensic re-interpretation of protest	Acts of self-defense or dissent are redefined as symptoms of illness	Eliminates legitimacy of resistance, justifies further coercion
Physical health deterioration	Forced medication causes long-term damage without addressing underlying suffering	Increases dependency, vulnerability, and chronicity
Social death	Isolation, forced treatments, and stigma result in permanent loss of community ties and self-agency	Perpetuates exclusion, unemployment, and juridical disadvantage
Reputational erasure	Labeling as mentally ill undermines credibility across social and legal domains	Facilitates exploitation and sustained structural disadvantage

Mechanisms of structural abuse and life destruction under coercive psychiatric regimes.

In parallel, certain family members—particularly those complicit in or affected by abusive dynamics—support forced treatment as a means of restoring control or avoiding personal accountability, often reinforcing the silencing of victims and the concealment of systemic violence (Burstow, 2015; Breggin, 1991). Legal actors legitimize these practices by deferring to clinical authority and minimizing scrutiny of human rights infringements, under the illusion of due process (Sisti et al., 2021; Puras, 2017). Meanwhile, sociomedical educators perpetuate these dynamics by valorizing biomedical epistemologies, marginalizing user-led and experiential knowledge, and suppressing emancipatory frameworks in curricula and policy design (Foucault, 1975/2003; Rose et al., 2019). The result is a structurally reproduced alliance of incentives—financial, political, academic, and symbolic—that enforces coercive paradigms in psychiatric care, despite substantial evidence of harm and widespread international calls for reform.

Psychiatric institutions and their professional actors operate within environments often shielded from effective oversight, where abuse can be routinized under clinical, legal, and familial legitimacy. The structural dynamics of closed or semi-closed psychiatric systems frequently transform suffering into grounds for coercion, whereby expressions of pain, resistance, or dissent are reinterpreted as pathology (Foucault, 2003; Sisti et al., 2021). Reports of patients being restrained, silenced, or overmedicated for non-compliance rather than therapeutic need are well-documented in Spain and other European contexts (Gonzalez & Romero, 2020; Huertas, 2022).

These practices, far from isolated, are reinforced by institutional cultures where dissenters are framed as dangerous or unwell, legitimizing severe interventions (Moncrieff, 2022; Rose et al., 2019). Such environments foster complicity and silence: professionals hesitate to question routine protocols, and family members—whether abusive, misinformed, or desperate—are empowered to request or tolerate extreme measures. This coercive continuum not only compounds the initial trauma but also amplifies it through public institutions, extending stigma and exclusion into schools, workplaces, and courts (Puras, 2017; Kirmayer & Pedersen, 2014). The cycle of dehumanization and neglect becomes systemic, with devaluation of the psychiatric patient permeating the broader social fabric.

Table 20. Normalized punitive practices in psychiatric settings

Actor	Tool of Punishment or Control	Justification Used	Abuse Normalization Mechanism
Psychiatrist	Involuntary drugging, seclusion, diagnosis escalation	Therapeutic necessity, risk management	Clinical authority interpreted as infallible judgment
Nurse	Physical restraints, isolation, verbal intimidation	Behavioral control, safety protocol	Culture of obedience, understaffing, and hierarchical impunity
Psychologist	Misinterpretation of trauma, gaslighting, denial of therapeutic alliance	Lack of insight, secondary gains	Pathologization of complaint or critique
Family member	False claims, reinforcement of diagnosis, denial of support	Duty of care, concern for safety	No external oversight; deference to family in institutional contexts
Social worker	Blocking access to housing or autonomy-related services	Non-compliance, mental incapacity	Collaboration with medical files without independent evaluation
Community institutions	Disregard for complaints, deferral to psychiatric authority	Professional consensus, risk avoidance	Psychiatric documents dominate administrative and judicial decisions

Punitive practices and mechanisms enabling systemic abuse across psychiatric and family settings.

In contrast to treat as usual as normalized nowadays, psychosocial and community-based interventions—rooted in trauma-informed principles, relational continuity, dietary stabilization, housing-first models, and collective support—consistently outperform pharmacocentric approaches on outcomes such as functional recovery, subjective well-being, and long-term autonomy, despite lack of support in implementation and well funded, supported research (Kirmayer & Ban, 2013; Hopper et al., 2010; Slade et al., 2014). These models often demand labor-intensive, context-sensitive infrastructures and a therapeutic culture grounded in trust, co-responsibility, and shared decision-making—elements inherently misaligned with the austerity frameworks governing modern public health systems, and lack of education in health promoting behaviours, support mechanisms and prevention. Pharmaceutical industries capitalize on these structural contradictions: with global psychotropic sales exceeding $80 billion annually, the economic incentive to promote pharmacological compliance remains overwhelming (IQVIA, 2022). Marketing campaigns, key opinion leaders, and diagnostic inflation mechanisms—particularly those embedded in DSM revisions and clinical guidelines—ensure the reproduction of medicalized narratives, marginalizing dissent and alternative epistemologies (Cosgrove & Whitaker, 2015; Frances, 2013).

Table 13 - Rationalizations, dissonances, and incentives in psychiatric care nowadays

Actor / Group	Stated Justification	Dissonance with Empirical Reality	Underlying Incentives (Money, Power, Status)
Academic psychiatrists / professors	Evidence-based standards; safety; biological causality	Ongoing controversy over evidence quality and generalizability	Professional prestige; industry ties; influence in policy and curricula
Politicians / public health officials	Public order, risk reduction, budgetary efficiency	Failure to address structural causes of distress; chronicity worsens under treatment-as-usual (Sisti et al., 2021)	Political capital; avoidance of structural reform; outsourcing responsibility
Practicing psychiatrists / clinicians	Clinical necessity; symptom management; legal safety	Time constraints, resource gaps, and lack of support for alternatives drive overreliance on medication	Avoidance of liability; institutional conformity; procedural simplicity
Pharmaceutical-aligned researchers	Scientific advancement; optimization of treatment	Selective publication, ghostwriting, and financial conflicts undermine neutrality	Research funding; career progression; corporate affiliations
Nurses / support staff	Patient and ward safety; work manageability	Frequent distress caused by forced measures and lack of training in trauma-informed care	Job security; lack of systemic alternatives; burnout deflection
Family members (ambivalent/abusive)	'Stabilization', obedience, relief from caregiving burden	Often participate in cycles of control, scapegoating, or silence about abuse	Restored order; avoidance of accountability; social legitimacy
Legal actors / judicial systems	Due process followed; therapeutic exception	Often rely on institutional claims, overlook human rights violations	Case resolution ease; institutional trust; avoidance of political conflict
Sociomedical educators	Enforcing allegedly neutral so-called science processes; appearance of technocratic rationality	Marginalize critical and user-led perspectives; reinforce top-down power	Intellectual gatekeeping; ideological alignment; systemic career incentives

Rationalizations used by institutional actors to justify coercive pharmacological interventions in mental health, alongside empirical dissonances and material or symbolic incentives maintaining the current system. Evidence suggests that these justifications often obscure deeper patterns of neglect, coercion, and power asymmetry.

The institutional preference for coercive pharmacotherapy is thus not a matter of clinical efficacy but of bureaucratic manageability. Sedated patients require fewer personnel, pose fewer challenges to institutional authority, and can be processed through standardized protocols with minimal relational investment (Rose, 2018). The medical framing of resistance—as symptom, relapse, or risk—serves to delegitimize calls for change, branding survivor knowledge, reformist critique, and epistemic plurality as irrational or even dangerous (Burstow, 2015; Russo & Sweeney, 2016). This logic aligns psychiatric governance with carceral paradigms: the primary objective becomes containment, not healing. In this light, the persistence of coercive pharmacology reflects not

scientific consensus but institutional inertia, economic coercion, and political disavowal of structural causality.

In this regime, forced drugging functions as a tactical erasure. It bypasses the labor of listening and the risk of uncertainty by imposing a pharmacological mute button on the organism. Justifications such as alleged lack of insight, noncompliance to forced treatments, and risk prevention as fear mongering are often deployed preemptively and very aggressively from positions of deposited trust, power, duty to care and pretended competent authority, not as responses to concrete danger but as expressions of clinical discomfort with emotional intensity, narrative deviation, or epistemic challenge (O'Hagan, 2006; Hopper et al., 2010). The pathologization of protest, grief, or spiritual crisis as symptoms of mental illness renders dissent unhearable. Worse, the very act of protesting coercion becomes diagnostic evidence reinforcing the original label. This circular logic transforms psychiatric practice into a self-validating system of control, where harm inflicted under the banner of care is not only normalized but rendered unchallengeable. Moreover, the physiological and psychological consequences of such practices are profound. Individuals subjected to forced medication often report feelings of depersonalization, cognitive flattening, and internalized stigma. The pharmacological regime does not heal but disciplines—dampening bodily wisdom, disrupting metabolic integrity, and undermining trust in one's own perception (Moncrieff, 2022; Gøtzsche, 2015). In this way, psychiatry mimics and magnifies the original harms it claims to treat. Rather than acting as an agent of restoration, it becomes an instrument of slow violence—a medicalized continuation of earlier disciplinary forms like confinement, whipping, or exorcism. Modern medicine, under these conditions, ceases to be a healing art and becomes an apparatus of erasure, where the suffering body is rendered inert for systemic convenience.

The diagnostic regime mapped across the historical tables in this dissertation is not a vestige of the past, but an active modality of control in the present. The ethical imperative is not abstract. It demands the end of coercion, the rejection of pathologized dissent, and the creation of infrastructures that support life, not submission. Medicine must become what it falsely claims to be: a space of healing, justice, and emancipated knowledge.

Table 14. Historical Evolution of Psychiatric Interventions, 20th–21st Century

Period	Pharmacological Interventions	Physical/Institutional Approaches	Psychosocial/ Community Approaches	Force and Coercion	Target Populations and Patterns
1900–1950	Barbiturates, early antipsychotics, insulin shock	Asylums, electroconvulsive therapy, lobotomies	Limited, confined to psychoanalysis (elitist)	Often involuntary; massive confinement	Women, poor, disabled, colonized subjects framed as deviant
1950–1970	Chlorpromazine, lithium, MAOIs	Deinstitutionalization begins, ECT remains	Rise of social psychiatry, family therapy	Ambiguous: outpatient clinics expand, coercion persists	Allegedly therapeutic force; racial minorities disproportionately institutionalized
1970–1990	Benzodiazepines, SSRIs, atypical antipsychotics	Hospital downsizing, rise of psychiatric wards in general hospitals	Community mental health centers promoted (esp. post-WHO 1979)	Restraints used, often unregulated; lack of rights awareness	Women medicalized for non-compliance or despair, anti-psychiatric critiques rise

Period	Pharmacological Interventions	Physical/Institutional Approaches	Psychosocial/ Community Approaches	Force and Coercion	Target Populations and Patterns
1990–2010	Polypharmacy, overprescription, off-label uses, stimulant and other drugs use rise in children population	Forensic psychiatry and emergency interventions dominate	Global Mental Health movement emerges, posing both risks and opportunities	Legislation increases procedural safeguards, but implementation weak	Rise in psychotropics among elderly, youth, and racialized populations
2010–present	Long-acting injectables, digital therapeutics, and overprescription trends worsen	Acute care, seclusion, mechanical restraints still widespread	Trauma-informed care, recovery-oriented approaches barely adopted	UN/WHO condemn coercion; yet coercive practices remain common	Shared decision-making discussed but rarely implemented; structural abuse persists

Main treatments, modalities, and political logics across global and European contexts. Historical overview of psychiatric practice by dominant treatment logics, coercion levels, and affected populations (1900–present). Based on scientific and policy literature.

From the mid-20th century onward, psychiatry increasingly aligned with biomedical paradigms, propelled by the advent of psychotropic drugs such as chlorpromazine in the 1950s and later benzodiazepines and antidepressants. However, from the 1970s to the early 2000s, several global institutions, notably the World Health Organization (WHO), advocated a community-based, human rights-oriented mental health framework, emphasizing psychosocial support, local integration, and non-coercive care. Landmark reports such as WHO's 2001 World Health Report and its 2013 Mental Health Action Plan reiterated the centrality of rights-based, locally delivered services over hospitalization and pharmacological dominance . Nevertheless, geopolitical realignments and pharmaceutical industry lobbying reshaped this vision. Structural adjustment policies, austerity programs, and market pressures led to partial reversals or dilutions of earlier commitments, despite persistent rhetorical adherence to community-based goals .

Many global institutions, once again advocates for community-based mental health and primary care reform, have partially surrendered their transformative vision to pharmacological paradigms under economic and political pressures, despite insisting again on the need to get back on track (WHO, 2001; Patel et al., 2018). The human right to mental health has been diluted by vertical programming, cost-saving rationalizations, and conceptual frameworks that individualize trauma while ignoring its social determinants. Psychiatry—when tethered to industry and state repression—functions not as medicine but as technocratic violence masked by white coats. The moral foundation of medicine demands a different epistemology: one that sees suffering as meaningful, early signs as embodied intelligence, and care as relational repair, not submission.

The path forward demands more than reform—it demands epistemic justice. Restoring legitimacy to mental health systems requires a reorientation toward participatory models rooted in lived experience, ecological validity, and transdisciplinary synthesis. Human distress must be understood not as a deviation to be suppressed, but as an intelligent, embodied response to harmful or dehumanizing conditions. To chemically mute such signals without altering their causal conditions is to commit epistemic violence—a betrayal of both science and ethics. True care must begin with humility: the willingness to listen, to accompany, and to reallocate power. It must be trauma-literate,

context-aware, and politically alert. The scientific task is not to maintain the status quo through diagnostic inertia, but to generate frameworks that restore autonomy, dignity, and systemic repair.

Table 12. Timeline of global mental health advocacy and policy shifts

Period	Dominant Framing	Key Institutions	Goals Articulated	Political-Economic Context	Effectiveness
1970s–1980s	Public health integration	WHO, PAHO	Primary care inclusion of mental health (Alma-Ata, 1978)	Post-colonial restructuring, Cold War	Limited implementation; high institutional inertia
1990s	Neurobiological focus rises	NIMH, WPA, pharma-aligned agencies	Emphasis on diagnostics (e.g. DSM-IV), pharmaceutical rollout	Rise of global pharma, neoliberalism	Community-based models undercut by privatization
2001	Rights-based global reform	WHO (World Health Report 2001)	Community-based, user-involved services	Globalization, post-Soviet health transition	Key declarations; partial reform in few countries
2007–2013	mhGAP program	WHO, UNHRC	Integration in non-specialist settings, rights emphasis	Global burden of disease framing	Some regional impact; insufficient structural funding
2018–present	Human rights, LGBT+, anti-racism, SDGs, One Health	UN, WHO, CRPD	End coercion, promote autonomy and choice	UNCRPD enforcement, Sustainable Development Goals	Systemic coercion persists; calls for compliance unheeded in many contexts

International mental health advocacy phases, from primary care reform to human rights-based frameworks, with limited structural transformation.

The capture of scientific authority by dogmatic structures—whether in psychiatry, policy, or public health—represents not a failure of knowledge, but of its institutional custodianship. Fanaticism, in both religious and secular dress, operates by the foreclosure of doubt and the punitive silencing of alternative explanation. It is precisely this—immunity to falsification—that Karl Popper identified as the hallmark of pseudoscience: a framework that protects itself from revision not by empirical accuracy, but by circular reasoning and rhetorical violence (Popper, 1959). The contemporary mental health paradigm, particularly when grounded in coercive pharmacology or bureaucratic reductionism, routinely violates this standard. Claims of biochemical imbalance are presented as explanatory despite the absence of specific biomarkers; treatments are deemed effective despite deteriorating outcomes; resistance is reframed not as informed dissent, but as further proof of illness. The model thus becomes unfalsifiable, self-validating, and immune to correction—a closed ideological loop rather than an open scientific inquiry (Moncrieff, 2022; Gøtzsche, 2015; Cosgrove et al., 2020).

This epistemic corruption is not accidental—it serves structural interests. By cloaking power in scientific language, institutions evade scrutiny while preserving systems of extraction and control. Medical violence is recast as care, institutional neglect as compliance failure, and social despair as chemical disorder. Yet real science begins with humility: the willingness to be wrong, to revise, to listen. Its foundation lies not in certainty but in method—testability, replicability, and transparency.

The solution, then, is not merely technical but ethical. It begins by restoring education that teaches how to think, not what to think. It requires the funding of public systems not as mechanisms of containment, but of flourishing. Where knowledge flows freely and people are taught to read their own bodies and environments—rather than defer blindly to broken institutions—hope becomes practical. It is not idealism to believe in better; it is realism, once the distortions of ideology are cleared. As simple as it is difficult, the task before us is to be properly scientific, fully human, and never again complicit.

The thesis at hand stands in deliberate opposition to these trajectories. It asserts that every human being must have the autonomy to decide, to know, and to be believed. No institution—medical, political, or educational—has the moral right to override embodied awareness or collective truth. What remains to be rebuilt is not simply a better mental health system, but the conditions for mutual flourishing: education that liberates, nutrition that heals, support that restores, and law that protects against domination. The scientific task is not the neutral observation of collapse—it is to stop it, while there is still time. The scientist task, therefore, is not to merely to chart the epidemiology of violence or trace its sociological contours, but to denaturalize its logics. Participatory action research is geared to end the problem, work it out, not merely account about it and those who cause and keep it as is, block any attempts at restoring systemic health, legality, or implementing better practices. This endeavour requires a biohistorical approach capable of both exposing the genealogies of coercion, the crimes, the violence, all metabolic and psychological cost of suppression, but also the complicity of others, the falsification of medical neutrality in structures engineered to punish the wounded. It calls for dismantling the administrative language that sanitizes structural cruelty and replacing it with clear, transdisciplinary frameworks for justice rooted in human dignity, embodied awareness, and systemic repair.

1.2. General introduction: scientific approach and structural urgency

This doctoral dissertation and compendium of publications is grounded in a verifiable observation supported by a wide body of empirical evidence: contemporary psychiatric and biomedical systems, both in Spain and across much of the Euro-Western sphere, continue to perpetuate structural violence under the guise of therapeutic intervention. Rather than addressing the underlying causes of psychological and social suffering, these systems reproduce coercive and denial-based practices that validate clinical and administrative protocols leading to chronic harm, loss of agency, and epistemic delegitimization of those affected (Rose, 2018; Moncrieff, 2008; Busfield, 2011). This condition is not accidental. It emerges from the historical sedimentation of institutional failures, legal permissiveness, and epistemological hierarchies that prioritize biomedical reductionism over experiential knowledge, ethical deliberation, and transdisciplinary approaches (Foucault, 2003; Bracken et al., 2012). What presents itself as standardized care often masks routinized neglect, dependency-producing interventions, and diagnostic paradigms devoid of emancipatory purpose.

Using a biocultural and action-research lens, this thesis investigates the systemic imposition of treatment without informed consent, the pathologization of non-normative behaviors, and the exclusion of critical voices from decision-making processes in psychiatry and mental health services. These elements constitute a network of normalized punitive mechanisms sustained by permissive legal frameworks, professional routines that prioritize risk-aversion over relational understanding, and academic discourses that conflate clinical utility with moral conformity (Mol, 2008; Russo & Sweeney, 2016; Rogers & Pilgrim, 2010). The psychiatric apparatus—understood

here not merely as a clinical subsystem but as a socio-political operator—functions as a central node in the institutionalization of suffering, particularly through its alliance with custodial logics, pharmacological dominance, and the bureaucratic neutralization of patient agency (Frances, 2013; Spandler & McWade, 2021). This investigation proposes that such conditions are not simply misapplications of otherwise benevolent science, but structured patterns of harm embedded in the current design of care.

This investigation is grounded in a legally and scientifically rigorous framework, integrating mixed-methods data drawn from in-depth interviews, statistical analyses, participant observation, and primary documentation of lived cases. The research systematically evidences how the current Spanish mental health system, rather than upholding the fundamental rights of vulnerable individuals, frequently enables—and in some cases structurally incentivizes—their violation (Arjona et al., 2021; Gómez Pellón, 2023). These abuses are not anomalies attributable to isolated malpractice, but rather embedded features of an operational paradigm oriented toward social regulation through medicalized exclusion (Russo & Sweeney, 2016; Puras & Gooding, 2019). The complicity of institutional actors—including psychiatric services, family networks, judicial authorities, and administrative bodies—produces a web of coercion that frames distress as disorder, nonconformity as pathology, and resistance as risk to be managed. The clinical protocols implemented under this regime are often disconnected from evidence-based standards of care, and instead reflect bureaucratic expedience, medico-legal risk management, and cultural norms of compliance (Rose, 2018; Moncrieff et al., 2011).

Table 13 - Sociocultural models of psychiatry and abuses of the discipline to punish, control

Psychiatric tradition	Violence Inflicted	Ideological Motifs	Biological framing
Buddhist-informed	Spiritual bypassing, behavioral conformity	Detachment from suffering, spiritual integration	Meditation as neurological regulation
Classical asylum	Confinement, dehumanization, moral discipline	Social order, moral hygiene	Degeneration theory, inherited inferiority
Freudian psychoanalysis	Verbal domination, pathologizing normativity	Libidinal economy, repression theory	Somatic roots of hysteria and libido
Lacanian psychoanalysis	Ambiguity, institutional cultism, symbolic violence	Subject split, language mastery	Linguistic inscription over neurology
Soviet psychiatry	Political imprisonment, psychiatric labeling	Ideological conformity, state security	Material brain-based deviance
Democratic psychiatry	Minimal; rights-based disruption of coercion	Equality, emancipation, community care	Critique of reductionism, neuroplasticity support
Postcolonial ethnopsychiatry	Cultural assimilation, epistemic domination	Colonial control, identity erasure	Organicism denied or distorted via 'soul sickness'
Neocolonial psychiatry	Criminalization, silencing of resistance	Order maintenance, cultural export	Diagnostic mimicry of Western pathologies
Community-based and open dialogue models	Low; minimal pharmacological or physical coercion	Dialogue, subjectivity, social recovery	Complex adaptive neurobiology

Paradigms of psychiatry with their historical and contemporary misuses to exert punitive control, marginalize dissent, and enforce normative behavior under the guise of care.

The functional nature of these violations must be critically emphasized. Far from being exceptional lapses in otherwise humane systems, coercive practices—such as forced medication, non-consensual hospitalization, and long-term institutionalization—are reproducible outputs of a model that de-emphasizes relational understanding and community-based support in favor of institutional containment and pharmacological control (Dain, 2012; O'Hagan, 2014). The fact that these interventions are routinely applied to individuals in moments of extreme vulnerability—including survivors of violence, those in psychosocial crisis, and minors experiencing systemic neglect—raises urgent questions of medical ethics, human rights, and epistemic injustice (LeFrançois et al., 2013; Gooding, 2020). Confinement and coercion are often implemented not for therapeutic purposes, but to resolve social discomfort, familial rejection, or judicial backlog—thus repurposing psychiatric settings as carceral spaces. The consequences are long-term: stigma, dependency, learned helplessness, and sustained exposure to structural violence under the guise of care (Sweeney et al., 2018; Spandler & McWade, 2021). As this thesis argues, these outcomes are neither accidental nor unintended. They are predictable results of systems that prioritize social order over person-centered support, and risk-aversion over relational healing.

International health authorities and human rights bodies now unequivocally call for the eradication of coercive practices in mental health care and the implementation of holistic, rights-based support systems. The World Health Organization's recent *Blueprint for Mental Health Policy and Law Reform* explicitly mandates the elimination of involuntary admission, forced treatment, and substitute decision-making, advocating instead for supported decision-making frameworks, full respect for informed consent, and the integration of economic, educational, housing, and employment policies into mental health planning (WHO, 2025; WHO & OHCHR, 2024). Similarly, WHO-Europe has illuminated widespread egregious rights violations—such as excessive use of seclusion and restraint—across 98 long-term institutions, and urges member states to adopt legislative constraints and non-coercive alternatives (WHO, 2025). The Council of Europe likewise highlights good practices that promote voluntary mental health services, advanced through hospital- and community-based initiatives, peer-support models, and enhanced professional training aimed at reducing coercion (Council of Europe, 2022). These positions are reinforced by the United Nations Convention on the Rights of Persons with Disabilities, which demands an end to substitute decision-making and establishes supported, autonomous health decision-making as an inalienable right (UN CRPD, 2006).

Table 14 - Biological and allegedly biological models of psychiatry

Psychiatric tradition	Violence Inflicted	Ideological Motifs	Social Framing
Francoist	Political repression through biological deviance	Biological inferiority justifying national moral order	Moral deviation encoded in bloodline and class
National Socialist	Sterilization, extermination by racial-biological doctrine	Racial hygiene, eugenic cleansing, societal purification	Biological race as societal value metric
Biologicist Psychiatry	Polypharmacy, chronicization, dismissal of cause	Neurochemical correction, diagnostic standardization	Functional adaptation to disorder; lifestyle blamed
Nutritional Psychiatry	Neglect of social context, over-focus on micronutrients	Gut-brain restoration, micronutrient optimization	Diet-driven personality traits and cognition
Metabolic Psychiatry	Metabolic labeling, medicalization of stress	Systemic resilience, glucose-lipid-mental health link	Stress as pathology of social performance
Psychoneuroimmunology-based Approaches	Reductive immune profiling, biomarker essentialism	Inflammation control, cytokine-mediated regulation	Social threat read as immune activation
Neuroendocrine-Informed Models	Hormonal manipulation, gendered bias	Hormonal balance, HPA axis recalibration	Stress exposure framed through gendered life roles
Microbiota-Gut-Brain Axis Psychiatry	Overinterpretation of correlations, probiotic overselling	Barrier protection, digestive-immune co-regulation	Western diet and urbanization as disease vectors
Systems Biology	Datafied abstraction, individual burden framing	Multi-scalar modeling, predictive health frameworks	Individualized responsibility for failure to self-regulate

Biologically framed psychiatric models, their scientific foundations and controversies, including critique of chemical imbalance theories and reductionist diagnostic frameworks.

Despite clear and consistent international standards, the translation of policy into practice remains severely lagging. Peer-reviewed evaluations demonstrate that countries with coercion-reduction programmes—such as Denmark, Finland, Germany, Israel, and Italy—have achieved significant reductions in forced measures through staff training in de-escalation, open-door ward policies, and community integration (Mental Health Europe, 2019; WHO, 2022). However, a pan-European survey within FOSTREN revealed that only 31 % of experts believed that total abolition of coercion was feasible in current systems—a perception rooted in persistent risk-averse cultures and legal ambiguity regarding dangerousness (Birkeland et al., 2024). In contrast, the renowned Italian Trieste model, underpinned by the Basaglia Law, demonstrates that complete closure of psychiatric asylums and reinvestment into community services can reduce suicide rates and improve social inclusion—albeit requiring political commitment, cross-sector coordination, and sustained investment (Financial Times, 2024; Tansella, 1986). Shared decision-making tools originating from the United States and supported by SAMHSA have been shown to increase patient knowledge, autonomy, satisfaction, and adherence, while diminishing coercion—but their integration remains marginal in most European health systems (SAMHSA, 2009). The literature unanimously indicates that systemic transformation—grounded in action-research, continuous feedback loops, workforce retraining, and legal realignment—is essential to prevent cycles of harm, to move from treatment-

as-usual to treatment-as-best, and to realize a genuinely emancipatory mental health framework (Puras & Gooding, 2019; Russo & Sweeney, 2016; WHO, 2025).

Table 15 - Coercive measures in psychiatric and general healthcare settings in spain

Setting	Coercive Practices
Primary Care	Coercion is primarily symbolic. Patients pressured into pharmacological compliance. Referral used to discipline rather than support (Moncrieff, 2022).
Outpatient Mental Health Units	Legal coercion via guardianship and compulsory outpatient treatment. Emergency measures sometimes bypass procedural safeguards (Muñoz & Lobato, 2021).
Hospital Psychiatry Wards	Mechanical restraints and isolation used routinely under therapeutic pretext. Often applied punitively or to suppress distress (González Pinto et al., 2020; WHO, 2021).
Forensic Psychiatry Units	Prolonged seclusion and forced medication normalized. Coercion institutionalized and poorly monitored. Human rights safeguards minimal (Rodríguez-Pulido et al., 2021).

Common coercive practices in mental health settings in Spain, showing normalization of physical and legal control mechanisms.

Despite legal protections that restrict physical restraint and seclusion to exceptionally rare, time-limited circumstances, Spanish psychiatric services routinely utilize these coercive practices in non-therapeutic ways—often to punish, control, or manage patients rather than provide care (Gutiérrez & González, 2022; Fernández, 2021). National legislation such as Ley General de Sanidad and Ley de Autonomía del Paciente nominally imposes strict criteria: only as last resort, with proportionality and recording requirements, and always subject to external oversight (BOE, 2002; BOE, 2003). However, observational studies demonstrate widespread non-compliance. In hospital-based settings, structured surveys and patient follow-up interviews reveal that between 15% and 31% of psychiatric inpatients have experienced at least one episode of mechanical or pharmacological restraint annually; in many cases, staff justify these measures as necessary for unit control rather than actual clinical benefit (Martínez-Cañavate et al., 2023; Pérez et al., 2020). Seclusion, likewise, is reported to occur for reasons of convenience or institutional expedience—patients are isolated not because of acute risk, but as a disciplinary measure against non-compliant behavior (Ruiz-Limón et al., 2022). These actions are taking place in resource-poor, overstretched wards where structural support is minimal, contributing to a decline in relational care and escalating medication doses, with limited attention beyond symptom suppression (Ortega-Carrion & Moreno, 2022).

The consequences of these practices are deeply harmful and systematically under-recognized. Empirical evidence links frequent use of restraint and seclusion to post-traumatic stress, deterioration in therapeutic alliance, and accelerated psychotic relapse (Svedberg et al., 2021; Steinert, 2018). Patients describe these experiences as dehumanizing—akin to institutional punishment—resulting in increased distrust in health providers, social withdrawal, and long-term avoidance of mental health services (Bowers et al., 2014; Goudge et al., 2016). Children subjected to coercive interventions during critical developmental periods show measurable impairments in emotional regulation, attachment formation, and neurodevelopment, with effects that persist into adulthood (Van der Kolk, 2014; Tarolla et al., 2015). The structural failure to provide holistic, socially informed care perpetuates a cycle: individuals with unmet psychosocial needs re-enter acute services, experience renewed coercion, and exit at baseline or worse (O'Hagan et al., 2023; Watson et al., 2022). These outcomes underscore that current practices reflect not isolated abuses,

but predictable results of systems built on normalization of institutional control. Without substantial reform—realigning wards with human rights frameworks, expanding community-based support, integrating trauma-informed training, and embedding ongoing action-research—Spain risks perpetuating cycles of harm under the guise of mental health care.

Table 16 - Patterns of psychotropic overprescription in spain by clinical setting

Setting	Overprescription of Psychotropics
Primary Care	Benzodiazepines and antidepressants frequently prescribed as first-line treatment without comprehensive assessment. Most affected: elderly and women (Abas et al., 2018; WHO, 2021).
Outpatient Mental Health Units	Polypharmacy is common. Medication is maintained over time without regular review. Consent procedures often inadequate or absent (Rose et al., 2022).
Hospital Psychiatry Wards	Dosage increases and drug switching are frequent during crises. Informed consent not prioritized. Medication dominates therapeutic approach (Rodríguez-Pulido et al., 2021).
Forensic Psychiatry Units	Antipsychotics administered systematically for behavioral containment. Alternatives rarely considered. Consent typically circumvented (Otero & Pérez, 2019).

Summary of overprescription trends in different healthcare settings in Spain, highlighting systemic pharmacological excess and lack of dialogical care.

The widespread overprescription of psychotropic medication in Spain constitutes not only a public health failure but a symptom of deeper structural dysfunctions within the mental health system. Benzodiazepines and other sedative-hypnotics remain among the most frequently prescribed drugs, particularly to women and older adults, despite well-documented risks of dependency, cognitive impairment, and deterioration of overall health (García-Campayo et al., 2015; Olfson et al., 2015). Rather than being addressed as a complex biopsychosocial phenomenon, insomnia is often reduced to a biochemical deficit or nuisance to be suppressed, ignoring evidence-based guidelines that recommend behavioral interventions, environmental modifications, and psychoeducation as first-line strategies (Qaseem et al., 2016). These approaches are rarely implemented in clinical practice, even though poor sleep hygiene is endemic and its correction both feasible and inexpensive. Children and adolescents, whose neurodevelopment requires stable circadian rhythms and restorative sleep, are particularly vulnerable to this neglect. Yet, the promotion of healthy sleep routines is virtually absent from public policy or pediatric care. The normalization of television use late into the night, unsupervised screen exposure, and chaotic home environments are all too common—and silently reinforced when pharmacological sedation substitutes educational or social responses.

This overreliance on medication coexists with alarming levels of coercion in psychiatric care. Although Spanish legislation limits the use of physical restraints to exceptional cases of imminent risk and for the shortest possible duration (Ley 41/2002, de autonomía del paciente), empirical studies and patient testimonies confirm that such practices are routine in many inpatient units and are often applied punitively, disproportionately, and without proper documentation (Puras, 2021; González-Hernández et al., 2020). The resort to mechanical restraints, forced medication, and prolonged seclusion reflects not therapeutic necessity, but institutional convenience and a failure of professional ethos. Far from representing a protective environment, psychiatric wards in Spain have

been repeatedly denounced by international bodies for degrading, traumatizing, or re-traumatizing vulnerable individuals, especially women and people with prior histories of abuse (Committee on the Rights of Persons with Disabilities [CRPD], 2019). The problem is not merely legal or administrative: it is deeply cultural. Consent is not requested, or is requested only once and never revisited. The subjective experience of patients is sidelined, diagnoses are often presented as definitive judgments rather than evolving hypotheses, and pharmacological adjustments are frequently made without any dialogical process. In such conditions, the relationship between caregiver and patient ceases to be one of alliance and becomes one of submission. Shared decision-making is rendered meaningless in a context where options are not genuinely offered and compliance is a precondition for access to services.

Table 17 - Contemporary institutional violence and social death

Targeted Group	Mechanism of Harm	Structural Role	Exploitative Driver
Psychiatric patients (institutionalized or community-surveilled)	Forced treatment, stigma, narrative erasure	Enforcing docility, silencing deviation	Pharma profit, diagnostic control
Migrant care workers and domestic laborers	Legal precarity, abuse, overwork, invisibility	Sustaining care economies without accountability	Free labor, racial-gender domination
Children in foster and child welfare systems	Neglect, instability, denied kinship, trauma recycling	Maintaining demographic control under austerity	Cost efficiency, institutional survival
Working-class and single mothers	Blame, moral shaming, no structural support	Enforcing gender roles and punishing autonomy	Moral policing, patriarchal pressure
Criminalized survivors (e.g. trafficked, abused, or resisting)	Punishment for survival, incarceration, medical neglect	Concealing systemic failure by criminalizing victims	Profit from bodies, punitive normalization
Political dissidents and health rights advocates	Surveillance, discreditation, legal harassment, exile	Preserving institutional impunity and silencing resistance	Political containment, epistemic violence

Forms of institutional coercion in modern psychiatric systems, examining how they result in social exclusion, identity erosion, and civic dispossession

The consequences are profound and long-lasting. Individuals who enter psychiatric services during crises—often triggered by social adversity, violence, or accumulated trauma—find themselves subjected to biomedical interventions that neither address nor acknowledge these root causes. They are maintained in states of chronicity, their records saturated with labels that shape future encounters, opportunities, and identities (Rose, 2006; Russo, 2018). Time allocated for appointments is minimal, with professionals focusing disproportionately on pharmacological regimes while neglecting holistic needs or socio-relational determinants. Follow-up may be irregular, trust eroded, and opportunities for personal recovery undermined. When patients deteriorate, the system typically responds with increased doses, not increased listening. This loop perpetuates both human suffering and professional burnout, cementing a model of care that is neither caring nor sustainable.

Table 18 - Neurobiology of social trauma, early-life developmental stage

Triggering Event or Condition	Key Neurophysiological Alterations	Subjective Experience	Clinical Misinterpretation
Chronic childhood neglect	Amygdala hyperactivity, mPFC hypoactivation	Rejection sensitivity, emotional flooding	Borderline disorder
Social exclusion, discrimination	DMN hypoactivity, SN hyperactivity	Identity confusion, internal chaos	Psychosis, dissociation
Forced migration, cultural loss	Insular disruption, vagal desynchrony	Bodily dislocation, numbness	Somatization
Recurrent interpersonal violence	HPA dysregulation, immune activation	Fatigue, panic, helplessness	Atypical depression, GAD
Institutional confinement	PAG activation, executive suppression	Muteness, cognitive narrowing	Negative symptoms

Early-life and institutional trauma triggers, associated physiological changes, subjective experiences, and psychiatric misinterpretations.

Table 3 presents a condensed translational framework linking early adverse experiences—including childhood neglect, social exclusion, forced displacement, interpersonal violence, and institutional confinement—to specific neurophysiological alterations consistently described in the literature (Teicher & Samson, 2016; Daskalakis et al., 2013; McLaughlin et al., 2019). These alterations are not random but involve conserved neurocircuits related to threat detection, social cognition, and autonomic regulation. In Spain, despite widespread evidence from both EU-funded studies and national reports (Ministerio de Sanidad, 2023), current psychiatric practice continues to mislabel these biologically coherent responses as idiopathic pathology. Catalonia’s Plan Integral de Salut Mental i Addiccions 2022–2026 acknowledges some of these dimensions, Yet, it remains structurally disconnected from the neurodevelopmental and systemic trauma literature. The implementation gap is exacerbated by decades of underinvestment, ideological resistance from conservative psychiatric sectors, and the absence of robust trauma-informed education in medical curricula.

Table 19 - Neurobiology of social trauma, later-life and end of life stage

Triggering Event or Condition	Key Neurophysiological Alterations	Subjective Experience	Clinical Misinterpretation
Sexual violence	Vagal collapse, limbic sensitization	Freeze, distrust, detachment	PTSD, bipolar disorder
Displacement (war/climate)	Hippocampal, dopaminergic disruption	Demotivation, disorientation	Depression, cognitive disorder
Death of caregiver	ACC, mPFC suppression, oxytocin disruption	Void, withdrawal, yearning	Bereavement disorder
Medical misdiagnosis or trauma	Gut-brain axis disturbance, inflammation	Bodily distrust, anxiety	Somatic symptom disorder
Loss of existential framework	DMN destabilization, limbic noise	Ontological insecurity	First episode psychosis

Later-life and end of life stage, relational, and existential trauma triggers, with their physiological, subjective, and diagnostic profiles.

Table 4 addresses a second category of trauma-related dysregulation involving sexual violence, forced displacement, caregiver loss, medical maltreatment, and ontological collapse. These events disrupt multisystem regulation at the neuroendocrine, oxytocinergic, and default mode levels, often producing states that mimic psychiatric syndromes but stem from relational rupture and failed safety signaling (Lanius et al., 2020; Herman, 1992; Kozlov et al., 2021). In Spain, these cases are common among institutionalized women, migrant populations, LGTBIQ+ youth, and those in coercive psychiatric care—Yet, practitioners lack both training and frameworks to understand or treat such cases with dignity. The EU Strategy on the Rights of the Child (2021) and the Council of Europe's calls for trauma-informed justice and healthcare systems (CoE, 2023) underscore the failure of member states, including Spain, to provide structural protections. Critical voices—ranging from grassroots survivor groups to international monitors—warn that diagnostic abuse and institutional trauma constitute ongoing violations of human rights, often with public funding.

Table 20 - Neurobiology of gut-brain toxicology and barrier breakdown, anxiety and fatigue

Triggering Factor	Key Pathophysiological Effects	Subjective Experience	Clinical Misinterpretation
Chronic ultra-processed food intake	Microbiota disruption, systemic inflammation	Brain fog, low mood, fatigue	Depression, chronic fatigue
Recurrent food poisoning (bacterial)	Tight junction breakdown, LPS translocation	Cramping, mood lability, malaise	Irritable bowel syndrome (IBS)
Environmental toxins (e.g. pesticides)	BBB permeability, oxidative stress	Cognitive slowness, irritability	Anxiety disorder, somatization
Heavy metal accumulation (e.g. lead)	Neurotoxicity, glial activation, mitochondrial injury	Memory issues, sensory sensitivity	Neurocognitive disorder
Gut dysbiosis due to antibiotic overuse	Microbial loss, serotonin metabolism disruption	Mood swings, anxiety, disorientation	Functional neurological disorder

Dietary, microbial, and environmental causes of gut-brain disruption and their misdiagnosis in clinical settings.

Table 5 synthesizes emerging evidence on how toxic dietary patterns, bacterial overexposure, environmental contaminants, and microbiota disruption contribute to gut-brain axis dysfunction—

often manifesting as fatigue, anxiety, cognitive slowness, or dissociation (Cryan et al., 2019; Ochoa-Repáraz & Kasper, 2020; Rieder et al., 2017). These presentations are frequently misdiagnosed as idiopathic psychiatric syndromes. Spain is particularly vulnerable due to high consumption of ultra-processed foods (40% of average intake), widespread pesticide use, and antibiotic overprescription (Agencia Española de Seguridad Alimentaria y Nutrición, 2022). Catalonia's biomedical infrastructure has the technical capacity to detect microbiome alterations, systemic inflammation, and toxic accumulation, Yet, such diagnostics remain rare in psychiatry. The failure to integrate this knowledge reflects a structural lag in translational practice, compounded by industry lobbies and fragmented health governance. European initiatives such as the EU4Health Programme and Horizon Europe's mental health missions now explicitly call for microbiota-informed, environmentally aware approaches to neuropsychiatry. Still, the bleeding continues: biologically repairable injuries are managed through lifelong labeling and sedation.

Table 21 - Neurobiology of gut-brain toxicology and barrier breakdown, psychotic experiences

Triggering Factor	Key Pathophysiological Effects	Subjective Experience	Clinical Misinterpretation
Undiagnosed celiac disease or gluten sensitivity	Zonulin increase, neuroinflammation, cerebellar dysfunction	Derealization, sensory overload, paranoia	Psychosis, schizophrenia spectrum disorder
Severe malnutrition (B12, folate, omega-3 deficits)	Neurotransmitter synthesis deficit, demyelination	Cognitive disorganization, hallucinoid states	Delusional disorder, bipolar disorder
Psychoactive fungal ingestion (accidental or misused)	Altered perception, serotonergic system disruption	Visual distortions, altered thought patterns	Substance-induced psychosis
Nightshade sensitivity (e.g. eggplant, tomato)	Cholinergic imbalance, gut-brain axis irritation	Anxiety, sleep disturbance, somatic discomfort	Generalized anxiety or mood disorder
Chronic gut inflammation and leaky gut	Persistent immune activation, astrocyte dysfunction	Emotional dysregulation, paranoid ideation	Schizoaffective disorder, borderline traits

This table focuses on microbiota disruption, blood-brain barrier permeability, mitochondrial injury, and neurotransmitter dysregulation, all of which are commonly misinterpreted in clinical practice as severe psychiatric disorders.

The recognition of physiological dysregulation by individuals actively engaged in health-promoting behaviors is neither anecdotal nor subjective: it reflects the predictive, embodied intelligence of homeostatic and allostatic mechanisms. Subtle deviations—such as cognitive slowing, gastrointestinal irregularity, sleep disruption, and emotional lability—are early somatic indicators of dysregulation across endocrine, immune, and neural systems (McEwen & Akil, 2020; Sterling, 2012). These indicators serve an adaptive role: they alert the organism before irreversible damage accrues. However, contemporary health systems systematically disregard these early signals, prioritizing diagnostic thresholds over proper needed preclinical interventions at all levels required.

Research confirms the convergence of neuroimmune-metabolic mechanisms underlying both psychiatric and somatic disease. Chronic low-grade inflammation and mitochondrial dysfunction, often triggered by lifestyle, environmental, and social adversity, are implicated in major depression, bipolar disorder, schizophrenia, and metabolic syndrome alike (Miller & Raison, 2016; Osimo et

al., 2020). Furthermore, gut-brain barrier integrity—frequently compromised by poor diet, antibiotics, stress, or undiagnosed food sensitivities—plays a critical role in neuroinflammatory priming, shaping both vulnerability to psychiatric symptoms and resistance to psychopharmacological treatment (Foster et al., 2017; Kelly et al., 2015). Nevertheless, the biomedical establishment continues to treat these phenomena in silos, dismissing lived bodily awareness as unscientific, and reifying diagnostic categories that obscure systemic, reversible causes. The failure is compounded by infrastructural and epistemic barriers, as health professionals are not trained to detect or treat early metabolic-psychiatric distress; reimbursement models do not reward prevention; and most clinical guidelines remain anchored in pharmacological paradigms that address symptoms rather than systemic etiology (WHO, 2022; Cosgrove et al., 2020). In consequence, patients must hunt for competent practitioners—often outside of public systems—and are forced to navigate contradictory, under-resourced pathways while their conditions worsen. Those who notice early shifts in cognition, motivation, or somatic state are rarely believed, particularly when socially marginalized. Instead, they are framed as anxious, somaticizing, or noncompliant—until the health system reclassifies them as chronic, dependent, and incurable.

To reverse this trajectory, medicine must reorient toward early warning integration, inter-systemic diagnostics, and lived experience as a legitimate clinical tool. Embodied knowledge is not speculative—it is grounded in millions of years of biological adaptation, and in contemporary evidence from psychoneuroimmunology and nutritional psychiatry. Failure to heed it, particularly in young or vulnerable populations, results in chronicity, institutional dependency, and preventable death. Restoring the body's signals to the center of clinical attention is not merely reform—it is the foundation of ethical, modern, translational medicine.

1.3. General introduction: state of the problem in Spain and the European Union

The current configuration of mental health systems in Spain—and in Catalonia in particular—manifests a deep structural misalignment between accumulated scientific evidence, internationally accepted human rights standards, and actual practice. Despite extensive literature on the biological embedding of early adversity, the neurodevelopmental impact of trauma, and the socio-structural determinants of mental distress, mental health services remain locked into an inverted pyramid of priorities. The majority of economic and clinical resources are allocated to pharmacological containment, whereas the most effective, developmentally crucial, and socially restorative interventions—such as early education, housing stability, trauma prevention, and integrative psychosocial care—remain either minimally supported or completely absent from structural design. In high-level meetings with Catalan policy leaders, this inversion was acknowledged explicitly: psychotropic medication dominates spending, while foundational determinants such as child protection, educational reform, and intersectoral preventive systems lack dedicated infrastructure. According to national data, over 80% of psychotropic prescriptions in Spain are initiated in primary care settings, typically without adequate psychological assessment or trauma inquiry (Ministerio de Sanidad, 2023). In Catalonia, similar trends prevail: up to 75% of patients in mental health pathways receive medication without parallel diagnostic or longitudinal support, and few services engage in structured deprescription (CatSalut, 2022; Observatori de Salut Mental de Catalunya, 2021).

This clinical and policy architecture persists despite overwhelming consensus from international health bodies, neuroscientific consortia, and trauma research networks that coercion, medicalization of distress, and exclusion of context produce long-term harm, undermine recovery, and violate ethical mandates. The WHO (2022) has warned of widespread systemic failure in the treatment of individuals experiencing psychological crisis, noting that pharmacological dominance and institutional coercion reproduce harm under the guise of care. The Council of Europe (2023) has called on member states to implement trauma-informed, rights-based mental health services, but no binding reforms have materialized in Spain. The Spanish Action Plan for Mental Health 2022–2024 and the Catalan Plan Integral de Salut Mental i Addiccions 2022–2026 contain language suggestive of community integration and prevention but lack enforceable financial mechanisms and remain disconnected from current neuroscientific and biocultural knowledge. Preventive investment in mental health in Spain amounts to less than 2% of the total health budget, one of the lowest rates among OECD countries (OECD, 2021), while trauma-informed schooling, ecological psychiatry, and social reintegration frameworks are structurally unsupported.

Table 19 - Psychotropic drugging in Spain by substance type and diagnostic trends in Spain

Substance Type	Diagnostic Category	Trend in Prescription (2018–2024)	Common Contexts of Forced Use	Notes on Growth Factors
Antipsychotics (oral)	Schizophrenia, bipolar	Moderate increase	Inpatient wards, outpatient, geriatrics	Protocolized use despite risk profiles
Antipsychotics (injectable depot)	Severe psychosis, SMI	Sharp increase in long-term settings	Compulsory outpatient treatment	Justified by 'non-compliance' definitions
Benzodiazepines	Anxiety, insomnia	Widespread stable use	Emergency wards, elderly homes	Low oversight, often non-consensual
Mood stabilizers	Bipolar disorder, aggression	Slight rise	Forensic and institutional use	Often adjunct to antipsychotics
Antidepressants (SSRIs, SNRIs)	Depression, PTSD	Generalized prescription increase	Primary care, elderly	Often prescribed without psychiatric oversight
Polypharmacy	Multi-diagnosis patients	Significant increase	Chronic inpatient and geriatric	Heightened risks and low reversibility

Trends in involuntary psychotropic medication use in Spain reveal a pattern of increased application, especially for long-acting injectable antipsychotics, frequently applied without proper safeguards. Benzodiazepines remain the most broadly used in non-consensual contexts, while polypharmacy in institutionalized individuals escalates despite evidence of long-term harm.

At the center of resistance to evidence-based reform is the institutional hegemony of biomedical psychiatry. Professional bodies and state-recognized networks of excellence such as CIBERSAM concentrate funding, agenda-setting power, and epistemological legitimacy within pharmacocentric paradigms, privileging randomized trials of medications and neurogenetic biomarkers while ignoring or actively excluding complex systems research, participatory methodologies, and interdisciplinary integration. The dominance of clinical psychiatry in Spanish universities ensures that the next generation of professionals receives limited exposure to trauma science, neurodevelopmental epidemiology, or biocultural psychiatry (López-Muñoz et al., 2020; Rössler et

al., 2022). Scholars working in these areas—especially those aligned with open science, community participation, or critical psychiatry—are routinely marginalized or treated as non-scientific. The defense of outdated paradigms is not merely discursive but institutional: critics of diagnostic inflation, coercive practices, or long-term polypharmacy face professional reprisal, legal threats, and research exclusion.

The cost of this stagnation is not theoretical but existential. Suicidality remains the leading external cause of death in young people aged 15 to 29 in Spain (INE, 2023), and chronic mental health disability has become one of the principal causes of long-term public dependency. Iatrogenic harms —from medication side effects to forced hospitalization—are rarely investigated and never systematically reported. Survivors are often silenced by a system that treats dissent as symptomatology and misinterpretation as pathology. Families are disempowered by rigid clinical hierarchies. Professionals themselves suffer: rates of burnout among psychiatrists and psychologists exceed 50% (SEPB, 2022), exacerbated by high caseloads, low compensation, and the absence of collaborative or restorative practice environments. Structural inertia and defensive governance create conditions under which no learning from past mistakes is possible, and no correction can be institutionalized. The result is not simply inefficiency, but an ongoing cycle of epistemic injustice and clinical violence in which human lives are misread, controlled, and subdued, rather than understood, supported, and restored.

Among the most severely affected populations are those already structurally marginalized: women, gender-diverse persons, survivors of sexual violence, racialized groups, and individuals in migration, foster care, or precarious legal status. These groups are not only overexposed to the traumatic conditions that produce dysregulation across neuroendocrine, immune, and autonomic systems (Teicher & Samson, 2016; Lanius et al., 2020), but are also consistently **misread by the diagnostic gaze**. Gendered stereotypes—emotional instability, manipulativeness, irrationality—remain embedded in clinical training and classification systems, leading to disproportionate diagnoses of personality disorders and somatoform syndromes among women and girls. Trans and non-binary individuals report disproportionately high rates of forced hospitalization and misdiagnosis, often underpinned by institutional ignorance of gender identity development and trauma (Kisely et al., 2017; Baril & Trevenen, 2014). Migrant populations are frequently pathologized through culturally unadapted symptom interpretations, with expressions of suffering recoded as delusion, paranoia, or non-compliance (Kirmayer & Ryder, 2016). Survivors of abuse who resist institutional narratives or medication regimens are often labeled treatment-resistant, while their trauma remains undocumented and untreated. As a result, these populations are maintained in a state of structural vulnerability—unable to report harm without being discredited, unable to seek justice without being reframed as unstable, and unable to recover without re-entering the same systems that inflicted harm.

This systematic dispossession is neither incidental nor fully invisible: it is codified through the language of clinical neutrality, legitimized by outdated nosological frameworks, and perpetuated by the failure to implement truly interdisciplinary systems of care. Spain, like much of Europe, remains caught between progressive discourse and regressive practice. National strategies cite equity and innovation, but the institutional logic remains deeply extractive, disciplinary, and pathologizing. Until these systems are rebuilt from the ground up—integrating neuroscience, law, education, and community healing—reform will remain superficial, and the reproduction of harm will continue under biomedical euphemism. As the scientific and ethical urgency deepens, the social legitimacy

of psychiatry itself is at risk. To remain relevant and reparative, psychiatry must cede control, share authority, and rebuild trust—one corrected mistake at a time, and one emancipated system at a time.

The misuse of psychiatric language, authority, and institutional power to silence survivors of violence represents not merely an epistemological failure but an organized structure of domination. In Spain and across the European Union, the reclassification of abuse reports as signs of psychiatric pathology is widespread, especially when those reports emerge from historically marginalized or stigmatized groups. Women, migrants, survivors of institutional abuse, children under state custody, and individuals marked by visible or presumed neurodivergence are frequently discredited through diagnostic codes that recast their suffering as disorder, their resistance as symptoms, and their desire for accountability as dangerous instability. Involuntary hospitalizations, false attributions of psychosis, and clinical files weaponized against testimony are routine mechanisms through which violence is denied and repeated (Sangiorgio et al., 2023; Minkowitz, 2014; Breggin & Breggin, 2021). The perpetrators of abuse—often within familial, medical, or institutional contexts—find in the psychiatric system a ready-made apparatus for disqualifying the truth-teller, with virtually no burden of proof.

This structural dynamic is deeply embedded in legal ambiguities and policy gaps. Although the Spanish Constitution (Articles 15 and 17) guarantees freedom from inhuman treatment and unlawful detention, and international frameworks such as the UN CRPD mandate equal legal capacity for all individuals regardless of disability, their implementation is structurally neutralized by national laws that enable substitution of consent and override due process through the invocation of mental disorder (Kayess & French, 2008; López-González et al., 2021). In Spain, Ley 1/2000 on civil procedure, Ley Orgánica 2/2006 on public health, and regional decrees allow professionals or relatives to instigate involuntary psychiatric evaluation without immediate judicial review, a process which routinely bypasses consent, silences contradictory testimony, and erases context. The role of professional bias—whether in clinicians, forensic experts, or court-appointed psychologists—is rarely questioned, and no independent forensic monitoring system exists. This means that psychiatric instruments can be deployed to remove custody, disqualify testimony, or forcibly medicate individuals who report abuse, dissent, or trauma—particularly when the alleged perpetrators occupy positions of medical, legal, or social authority (McWade, 2016; Busfield, 2013; WHO, 2022).

These practices are not simply clinical or legal anomalies—they reflect and reproduce a deeper social logic of exclusion, built upon ideological hierarchies of value. The diagnosis of borderline personality disorder, for instance, disproportionately applied to women who have survived sexual violence or coercive family systems, functions as a clinical category of moral discredit: accusations are reframed as manipulation, distress as instability, protest as danger (Shaw & Proctor, 2005; Caplan, 2014). Among migrants, particularly racialized men, the interpretation of cultural idioms of distress or embodied protest often triggers diagnostic responses such as acute psychosis or schizoaffective disorder, even when the social roots of suffering are plain. These patterns are not accidental. They are shaped by historically ingrained forms of domination, where psychiatry—like other state institutions—becomes an active participant in the governance of bodies deemed unruly, threatening, or politically inconvenient (Fanon, 1952/2008; Rose, 1985). There is no phobic reaction at play, no natural fear: this is not xenophobia, but ideological racism, a deliberate enactment of superiority through the repeated humiliation, misrecognition, and forced dependency of the Other. The claim that such actions emerge from cognitive bias or unconscious prejudice

cannot withstand scrutiny; they are deliberate, repeated, and systemically reinforced. The perpetrators are often aware, and the system offers them cover—not only through diagnostic authority, but through moral legitimization.

In everyday interactions, this moral scaffolding allows scorn, loathing, and derision to become normalized clinical attitudes. Health professionals, judges, and police officers may openly express contempt, laugh at disclosures of trauma, or accuse victims of fabrication—all without consequence. These reactions are not merely unprofessional; they are the emotional signature of institutional cruelty, one that enjoys participation in harm under the guise of expertise. Survivors are not simply disbelieved—they are humiliated, mocked, pathologized, and excluded. Their communications are recorded as symptomatic. Their history is rewritten in third-person summaries. Their suffering is reclassified as a risk to others. Once labeled, every future attempt to speak is reframed as further evidence of illness. This loop, once triggered, becomes nearly impossible to escape (Sweeney et al., 2016; Russo & Sweeney, 2016).

This is not a problem of individual ignorance, but of institutional permission. At every level, the apparatus is configured to facilitate silence and reward complicity. Professionals who witness abuse or malpractice and attempt to intervene are met with retaliation, exclusion, or threats to their licensure. Academic researchers who publish critical findings on diagnostic bias, coercion, or psychiatric violence struggle to receive funding, face career marginalization, and are frequently accused of lacking scientific objectivity. Patients who attempt to document their own experiences—to gather audio evidence, produce narratives, or report violations—are accused of paranoia or delusional ideation. Their recordings are confiscated; their notes ignored. In Spain, as in much of the EU, no structural mechanism exists to protect the psychiatric patient as a witness. Instead, they are rendered into legal non-persons by a system that presumes incapacity the moment the words mental illness is invoked. Even when supported by professionals, the testimony of survivors is rarely given the same weight as that of clinicians—even when those clinicians are the accused (Agamben, 1998; Minkowitz, 2014; Liegghio, 2013).

The consequences of this silencing are profound: survivors lose not only liberty, health, and recognition, but their very capacity to resist. Locked into institutions or dependent on professionals for certification of their sanity, they are denied the opportunity to build alternatives, to organize politically, or to seek justice through ordinary legal channels. Attempts to create peer networks are surveilled. Attempts to advocate are interpreted as dangerous overidentification. The system demands submission, not critique; gratitude, not truth. The early demise of so many individuals with psychiatric histories—whether through suicide, medical neglect, or social abandonment—is not a by-product but a consequence of this design. It is the result of a system that chooses containment over connection, control over comprehension, and punishment over protection. The failure to reform is not a matter of resources or complexity, but of institutional refusal to cede power. That refusal costs lives, and the growth and prevalence trends are in the wrong direction.

Recent evidence indicates that the use of psychotropic substances under conditions of coercion in Spain is not only persistent but growing, particularly in institutional and elder care settings. Antipsychotic medication, including long-acting injectable forms, has shown a notable increase in forced application, typically justified by perceived treatment non-adherence or administrative expediency rather than individual clinical assessment (Gonzalez & Romero, 2020). The use of

benzodiazepines remains widespread, especially in emergency care and residential facilities, where sedation is prioritized over dialogical intervention or trauma-informed care (Huertas, 2022).

Antidepressants, although often viewed as benign, are frequently administered without psychiatric supervision, especially in primary care contexts, leading to overprescription and neglect of root causes such as poverty or isolation (Olfson et al., 2015). Polypharmacy—particularly among institutionalized populations and individuals labeled with 'serious mental illness'—has risen steadily, despite its well-documented associations with reduced life expectancy, metabolic syndrome, and cognitive decline (De Hert et al., 2011; Vancampfort et al., 2015). These patterns reflect a systemic preference for pharmacological control as a substitute for adequate support structures, relational care, and respect for autonomy (Moncrieff, 2022; Kirmayer & Pedersen, 2014).

The implementation of involuntary pharmacological regimes often bypasses informed consent and undermines international human rights guidelines, such as those endorsed by the WHO (2021) and UN Special Rapporteurs on the right to health (Puras, 2017; Sisti et al., 2021). These findings reinforce the need for critical reassessment of psychiatric prescribing patterns and a shift toward more ethical, patient-centered, and evidence-based approaches in mental health care.