

From compliance to collaboration: shared decision-making
psychiatric violence, and the ethics of
medication management in contemporary Spain

A biocultural and transdisciplinary action research toward
structural reform and institutional responsibility

Henning (né Enric) Garcia Torrents

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Dedication

To the silenced, the disappeared, the punished for truth, this is yours. To my love and her father, denied justice, and to all whose lives were shattered by systems built to protect power, not people, this stands as witness. Justice is not optional, is owed. To Herti, my live, for our love. Thank you.

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Chapter 1. General framework and delimitation of the research

Abstract: This thesis argues that the Spanish psychiatric system, sustained by legal and administrative structures, systematically violates the autonomy and dignity of individuals through coercive, non-consensual practices masked as care. Diagnoses are imposed without empirical rigor, treatments administered without valid consent, and distress is decontextualized and medicalized, producing structural iatrogenic harm. At the root is the failure to implement shared decision-making and respect for the right to self-determination. Anchored in biocultural action research, this work integrates ethnographic, legal, and analytical evidence to document these mechanisms and propose grounded alternatives centered on human rights, prevention, and collaborative care. The findings demonstrate that ethical and effective mental health care must be rights-based, non-coercive, and built on trust and shared responsibility, not submission.

Resum: Aquesta tesi defensa que el sistema psiquiàtric espanyol, sostingut per estructures legalsthe researcher administratives, vulnera sistemàticament l'autonomiathe researcher la dignitat de les persones mitjançant pràctiques coercitivesthe researcher no consentides disfressades d'atenció. Es diagnostica sense rigor empíric, s'administra tractament sense consentiment vàlid,the researcher el patiment és descontextualitzatthe researcher medicalitzat, generant dany iatrogènic estructural. En l'arrel del problema hi ha la manca d'implementació de la presa de decisions compartidathe researcher del respecte pel dret a l'autodeterminació. Ancorat en la recerca-acció biocultural, aquest treball integra evidència etnogràfica, jurídicathe researcher analítica per documentar aquests mecanismesthe researcher proposar alternatives fonamentades centrades en els drets humans, la prevencióthe researcher una cura col·laborativa. Les troballes demostren que una atenció en salut mental èticahe researcher efectiva ha de basar-se en els drets, ser no coercitiva,the researcher construir-se sobre la confiançathe researcher la responsabilitat compartida, no sobre la submissió.

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). For most of history, the minority of healers who advocated for pluralistic, preventive, or dialogical approaches operated under permanent threat of execution, other punishments or forced exile. Their marginalization was not incidental but functional within paradigms in which medicine served conformity rather than autonomy (Foucault, 1963/2003). Roman medical organization, as precedent and a close example to how our own political and medical systems still operate nowadays, set as the foundation of our legal one, 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, electrotherapy	ether, 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 tasked 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, malnutrition, dietary restriction	Moralistic suffering, monastic 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 Preservation	& Skill 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, women silenced	lay Preserved Hippocratic and Galenic medicine	Heresy purges and imperial torture rituals
Islamic Age	Gender roles ambivalent; women could own property	Translation movement, Razi, Ibn Sina	Judicial amputations, corporal punishments
Western Medieval Europe	Serfdom, female orphans enslaved	witch-hunts, Monasteries kept rudimentary archives	Witch-burnings, pillories, sacrificial wars
Early Modern Europe	Factory discipline, commodification	sexual Renaissance 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

Era / Region		Health & Public Systems		Governance & Control Strategies		Population Obedience & Training	
Late Empire	Roman	Urban health infrastructure failing; aqueducts collapsing		Tax pressure, military conscription, Christianity unifying coercion		Discipline by legions, as declining civilian readiness	
Byzantine Empire		Hospital and orphanage system maintained in Constantinople		Bureaucratic complexity, theological policing		Monastic discipline, literacy enforced in clergy	
Islamic Age	Golden	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, authoritarianism	Church	Martial training for nobility, no peasant rights	
Early Europe	Modern	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 8 - Modern governance and social control

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

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 9 - Modern governance and institutionalized violence

Era / Region	Gender/Class Subjugation	Knowledge Preservation	& Skill	Pleasure/Profit from Violence
Early 20th Century (Global)	Pro-natalist industrial patriarchy	propaganda, Medical colonial science	academies,	Anatomical exploitation, forced labor profits
Mid 20th Century	Re-education camps, gender purging	Propaganda psychiatric policing	science,	Spectacular trials, state terror aesthetics
Late 20th Century	Sexual commodification, gig precarity	Elite managerialism	universities,	Prison-industrial complex, insurance markets
21st Century	Digital trafficking, biometric sorting	Platform monopolies	knowledge 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 10 - 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 Poverty	Reclassification of trauma or of social deprivation as chronic mental illness	Social psychiatry, disability assessments	Working-class populations, unemployed, single mothers
Carceral Expansion	Prison-like psychiatric wards, secure treatment centers, chemical restraints	Prisons, institutions, psychiatric units	juvenile closed Racialized youth, migrants, the homeless
Welfare Surveillance	Psychiatric labeling to restrict parental rights, enforce state guardianship, or justify state guardianship removals	Family courts, CPS, state guardianship bodies	Poor families, survivors of abuse, foster system entrants
Ideological education	Re- 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 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 11 - Cultural handling of altered states and mental distress, by era and region

Period / Region	Induced or States	Treated	Substances / Foods Used	Rituals and Settings	Interpretive Agents
Ancient Greece	Melancholy, catharsis, mania	divine	Wine, hellebore, potions	opium, honeyed Dionysian Asclepian incubation	rites, dream Temple philosophers, priests,
Vedic India	Mystical sorrow, mental	ecstasy, heat	Soma, butter, herbs	clarified ayurvedic Fire meditative seasonal fasting	sacrifices, chanting, Brahmins, healers, gurus,
Indigenous Amazon	Vision ancestral	quests, possession	Ayahuasca, chicha	tobacco, Night singing, immersion	rituals, group jungle Shamans, elder women
Classical China	Grief, spiritual	madness, imbalance	Ginseng, mushroom, rice	reishi wine Ancestral seasonal feasts, diaries	rituals, dream Daoist Confucian scholars, sages,
Medieval Islamicate	Spiritual melancholia, obsession		Ambergris, rosewater, saffron	Music therapy, Qur'anic dream interpretation	Hakims, theologians, Sufis
Medieval Europe	Demonic possession, melancholia		Absinthe, belladonna, and bread	fasting Exorcisms, flagellation, confession	fasting, Monks, inquisitors, barbers
Edo Japan	Existential societal shame	grief,	Green tea, rice, incense	fermented Theater (Noh), communal poetry	writing, Zen monks, poets, physicians
Andean Highlands	Soul loss, ecstatic mourning	trance,	Coca leaves, beer, llama fat	maize Dance, mountain offerings	bloodletting, Curanderos, community elders
Renaissance Europe	Black melancholy, madness	bile divine	Laudanum, tonics, red wine	herbal Patronage of alchemy, mirror-gazing	art, Artists, physicians, mystics
Yoruba Africa	West Spirit ecstatic healing	possession,	Palm wine, kola nut, herbal smokes	Drumming, divination ceremonies	trance, Orisha healers, priests,
Early Modern Europe	Hysteria, melancholia, rapture		Purgatives, opiates, hot baths	mercury, 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 12 - 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 (World Health Organization, 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 13 - 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 14 - 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 13 - Normalized punitive practices in psychiatric settings

Actor	Tool of Punishment or Control	Justification Used	Abuse Mechanism	Normalization
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 14 - Rationalizations, dissonances, and incentives in psychiatric care nowadays

Actor / Group	Stated Justification	Dissonance with Reality	Empirical 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; 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 unheardable. 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. 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 15 - Historical Evolution of Psychiatric Interventions, 20th–21st Century

Period	Pharmacological Interventions	Physical/Institutional Approaches	Psychosocial/Community Approaches	Force Coercion	and Target Populations and Patterns
1900–1950	Barbiturates, early antipsychotics, insulin shock	Asylums, electroconvulsive therapy, lobotomies	Limited, confined psychoanalysis (elitist)	Often to 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. of	Restraints often used, unregulated; lack of rights	Women medicalized for non-compliance or despair, anti-psychiatric critiques

Period	Pharmacological Interventions	Physical/Institutional Approaches	Psychosocial/Community Approaches	Force Coercion	and Target Populations and Patterns
			post-WHO (1979)	awareness	rise
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, overprescription trends worsen	Acute care, seclusion, and mechanical restraints still widespread	Trauma-informed recovery-oriented approaches barely adopted	UN/WHO condemn coercive practices remain common	Shared decision-making discussed 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 (World Health Organization), 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 (World Health Organization, 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 16 - 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, 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 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, CRPD 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 17 - 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, 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 (World Health Organization, 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 (World Health Organization, 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 18 - 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, on 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 profiling, essentialism	immune biomarker 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, overselling	Barrier protection, probiotic digestive-immune co-regulation	Western diet and co-urbanization as disease vectors
Systems Biology	Datafied abstraction, individual burden framing	Multi-scalar predictive modeling, 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 19 - 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 Health Units	Mental Legal coercion via guardianship and compulsory outpatient treatment. Emergency measures sometimes bypass procedural safeguards (Muñoz & Lobato, 2021).
Hospital Wards	Psychiatry Mechanical restraints and isolation used routinely under therapeutic pretext. Often applied punitively or to suppress distress (González Pinto et al., 2020; WHO, 2021).
Forensic Units	Psychiatry 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 20 - 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 Health Units	Mental	Polypharmacy is common. Medication is maintained over time without regular review. Consent procedures often inadequate or absent (Rose et al., 2022).
Hospital Wards	Psychiatry	Dosage increases and drug switching are frequent during crises. Informed consent not prioritized. Medication dominates therapeutic approach (Rodríguez-Pulido et al., 2021).
Forensic Units	Psychiatry	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 21 - Contemporary institutional violence and social death

Targeted Group	Mechanism of Harm	Structural Role	Exploitative Driver
Psychiatric patients (institutionalized or community-surveilled)	Forced stigma, erasure treatment, narrative	Enforcing docility, silencing deviation	Pharma profit, diagnostic control
Migrant care workers and domestic laborers	Legal precarity, abuse, overwork, invisibility	Sustaining economies without accountability	Free labor, racial-gender domination
Children in foster and child welfare systems	Neglect, instability, denied kinship, trauma recycling	Maintaining demographic under austerity	Control 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, harassment, exile	Preserving institutional legal 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 22 - Neurobiology of social trauma, early-life developmental stage

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

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

Table 22 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 Mentalthe researcher 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 23 - Neurobiology of social trauma, later-life and end of life stage

Triggering Condition	Event or Key Alterations	Neurophysiological	Subjective Experience	Clinical Misinterpretation
Sexual violence	Vagal sensitization	collapse, limbic	Freeze, detachment	distrust, PTSD, bipolar disorder
Displacement (war/climate)	Hippocampal, disruption	dopaminergic	Demotivation, disorientation	Depression, cognitive disorder
Death of caregiver	ACC, mPFC oxytocin disruption	suppression,	Void, yearning	withdrawal, Bereavement disorder
Medical misdiagnosis or trauma	Gut-brain inflammation	axis disturbance,	Bodily anxiety	distrust, Somatic disorder
Loss of framework	existential DMN noise	destabilization, limbic	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 23 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 24 - 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 24 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 25 - Neurobiology of gut-brain toxicology and barrier breakdown, psychotic experiences

Triggering Factor	Key Effects	Pathophysiological	Subjective Experience	Clinical Misinterpretation
Undiagnosed disease or sensitivity	celiac gluten	Zonulin increase, neuroinflammation, cerebellar dysfunction	Derealization, sensory overload, paranoia	Psychosis, schizophrenia spectrum disorder
Severe malnutrition (B12, folate, omega-3 deficits)	Neurotransmitter deficit, demyelination	synthesis	Cognitive disorganization, hallucinoid states	Delusional disorder, bipolar disorder
Psychoactive ingestion (accidental or misused)	Altered serotonergic system	perception, disruption	Visual distortions, altered thought patterns	Substance-induced psychosis
Nightshade sensitivity (e.g. eggplant, tomato)	Cholinergic brain axis irritation	imbalance, gut-	Anxiety, disturbance, discomfort	sleep somatic Generalized anxiety or mood disorder
Chronic 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 (World Health Organization, 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 institutional design of psychiatry in Spain bears the imprint of authoritarian, punitive, and disciplinary regimes inherited from the Franco dictatorship and never fully dismantled during the transition to democracy. Unlike other medical specialties, psychiatry retains exceptional legal mechanisms for the deprivation of liberty and forced intervention, justified not by acute somatic urgency but by vaguely defined behavioral risk. This exceptionality is not a scientific necessity but a sociohistorical legacy: the apparatus of control used to suppress dissent, marginalize political others, and maintain normative boundaries was never epistemically or ethically reformed. Instead, post-Francoist psychiatry preserved its juridical privileges under new biomedical rhetoric, consolidating a culture of impunity through diagnostic opacity, procedural ambiguity, and the performative use of clinical authority. In this configuration, coercion is not a pathological exception to be explained, but an ordinary feature of a system that normalizes medicalized forms of institutional violence under the sign of care. In the Spanish context, psychiatry historically served as an apparatus of ideological and political normalization, legitimized through state structures and exercised through institutions that concealed repressive functions under medical authority. From the Francoist era to contemporary neoliberalism, coercive practices -both symbolic and physical -have reflected a logic of social control rather than therapeutic intent. Medicalization was never neutral, and the profession's complicity in institutional violence is neither circumstantial nor obsolete. On the contrary, it reveals the structural embedding of psychiatry within disciplinary and punitive frameworks that shaped its development and continue to define its boundaries.

The current configuration of mental health systems in Spain 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).

Spanish legislation permits the application of coercive psychiatric measures -such as involuntary hospitalization, forced drugging, and mechanical restraint -based on presumed danger and without judicial guarantees equivalent to those required in criminal proceedings. This regime of exceptionality is fundamentally incompatible with constitutional protections of bodily integrity and personal liberty. The legal fiction that psychiatric decisions are purely medical, and thus outside the purview of constitutional law, creates a structural loophole in which abuse becomes normalized and impunity entrenched. Such mechanisms, when examined in light of the European Convention on Human Rights and UN Convention on the Rights of Persons with Disabilities, reveal not only professional discretion misused, but a failure of the democratic rule of law itself. The resulting asymmetry allows for deprivation of rights under the guise of therapeutic concern, while rendering appeal mechanisms opaque, inaccessible, or altogether nonexistent for those most affected.

In Spain, the persistence of coercive paradigms is further entrenched by what could be termed epistemological authoritarianism: a closed clinical discourse that pathologizes dissenting experts and refuses other explanations, violently and much more easily silencing victims as well. Such closure perpetuates an asymmetry of power in clinical interactions, in which questioning diagnosis or treatment is viewed as symptomatology rather than valid critique. This epistemic violence -deepened by structural classism, gendered assumptions, and cultural bias -systematically undermines patient voice and fosters dependence rather than autonomy. In this light, psychiatric practice becomes not merely a site of contested care, but a vector of political subjectivation, erasing heterodoxy in favor of managed compliance.

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 Mentalthe researcher 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 26 - Psychotropic drugging in Spain by substance type and diagnostic trends in Spain

Substance Type	Diagnostic Category	Trend Prescription (2018–2024)	in Common Contexts Forced Use	of 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.

The widespread acceptance of the biological model of mental illness in mainstream psychiatry has less to do with empirical consensus than with institutional inertia, commercial influence, and disciplinary coercion. As documented extensively in recent reviews, core assumptions such as the serotonin hypothesis for depression, dopamine dysregulation in schizophrenia, or any fixed neurochemical imbalance model lack replicable scientific support (Moncrieff et al., 2022; Gøtzsche, 2015; Lacasse & Leo, 2005). Yet, these unsubstantiated frameworks continue to serve as the rhetorical bedrock for psychopharmacological intervention, legitimizing both mass overprescription and involuntary treatment regimes across Europe and beyond (Cosgrove et al., 2020; Rose et al., 2019).

This disjunction between scientific knowledge and clinical practice reveals what can only be termed a pathological epistemology -an institutional refusal to course-correct despite mounting contradictory evidence. The persistence of drug-centered narratives, despite clear evidence of limited efficacy and widespread harm, including metabolic syndrome, cognitive impairment, dependency, and early mortality (De Hert et al., 2011; Vancampfort et al., 2015; Tihihonen et al.,

2009), is not benign error but structural negligence. The pharmacocentric model has created a global multibillion-euro market that not only captures therapeutic attention but erodes all capacity to think and act differently within the systems of care (Angell, 2011; Whitaker, 2011).

What makes this arrangement particularly devastating is the disciplinary violence enacted upon those professionals and researchers who challenge the dogma. From denial of funding to career obstruction and reputational attacks, dissenters -whether clinicians advocating for human rights, critical researchers uncovering bias, or service users demanding accountability -are systematically excluded (Burstow, 2015; Breggin, 1991). The requirement to conform to a dominant paradigm becomes a professional mandate, enforced through academic gatekeeping, institutional policies, and regulatory structures that function more as protectors of the industry than as guardians of scientific truth or patient welfare (Foucault, 1975/2003; Cosgrove et al., 2020).

Table 27 - Biological and allegedly biological models of psychiatry

Model or Theory	Key Assumptions	Scientific Critiques	Common Derived Practices	Harmful Implications
Monoamine Hypothesis	Mental illness caused by neurotransmitter imbalance	Lack of replicable biomarkers, oversimplification	Antidepressants, SSRIs as first-line treatment	Neglect of life context, side effects, chronic use
Dopamine Hypothesis of Schizophrenia	Excess dopamine leads to psychosis	Based on drug action not causal proof	Antipsychotic use for life, including injectables	Tardive dyskinesia, cognitive decline, metabolic damage
Genetic Predisposition Models	Mental illness largely hereditary	Polygenic risk scores inconclusive	Family risk profiling, early pharmacological intervention	Discrimination, fatalism, neglect of trauma
Neuroimaging Correlates as Diagnosis	Brain structure or activity patterns indicate disorder	High variability, no diagnostic utility	fMRI and CT scans for psychiatric justification	Misdiagnosis, false scientific legitimacy
Neurodevelopmental Deficit Theories	Early brain abnormalities predict psychiatric outcomes	Often confuse correlation with causation	Preemptive labeling in children	Stigmatization, lowered expectations, invasive surveillance
Pharmacocentric Disease Models	Medication corrects known brain dysfunction	Drug effects often not specific curative	Medication as standard, coercive use	Iatrogenic harm, silencing of patient voice
Epigenetic Reframing	Environment affects gene expression, justifying interventions	Promising but overused policy justifications	in Broad health and psychiatric initiatives	Biopolitical use to justify broad control strategies

Key biological models that dominate psychiatric discourse and practice, detailing their foundational assumptions, scientific critiques, common applications, and the major social and medical risks they pose when applied uncritically.

This is not only a failure of psychiatry but a broader indictment of the systems that allow science to be co-opted by profit, compliance, and convenience. To obscure this as mere difference in therapeutic philosophy is to legitimize fraud under the guise of pluralism. The consequence is a global structure of harm that continues to deny appropriate, person-centered, evidence-based care to millions -particularly the most vulnerable. Scientific integrity demands more than gestures of improvement; it requires the full abandonment of flawed foundations and the urgent elevation of relational, nutritional, ecological, and structurally informed interventions that have been sidelined, not because they failed, but because they were never profitable or compliant enough to be allowed their rightful place (Kirmayer & Pedersen, 2014; Patel et al., 2018).

In this context, table 103 illustrates the prevailing biological and pseudobiological models that underpin and justify coercive psychiatric systems, demonstrating how core assumptions, while presented as clinical truths, are scientifically unsubstantiated, economically incentivized, and epistemologically corrupt. The scientific flotation line -what separates plausible theory from enforceable fact -has been strategically submerged in psychiatry to facilitate the appearance of

legitimacy. This must be reversed. The science must again serve the people, not the market, and the cost of doing otherwise -human, social, and ethical -can no longer be tolerated.

Table 28 - Legal and institutional enablers of forced drugging in Spain and the European Union

Enabling mechanism	Description	Jurisdiction Level	Operational Context	Institutional Justification
Involuntary hospitalization laws	Allow detention for mental disorder if risk is alleged	National (Spain)	Psychiatric emergency admissions	Prevention of harm, public safety
Article 763 (Spain)	Legalizes treatment without consent under judicial authorization	National	Civil proceedings	Patient incapacity, substituted judgment
EU charter exceptions	Permits derogation from rights in interest of health and safety	European	Transnational coordination	Public health necessity
Penal code provisions	Allows coercion when linked to criminal offense or legal incapacitation	National	Forensic psychiatry	Legal responsibility, diminished capacity
Administrative protocols	Institutional guidelines enable medication without full patient participation	Regional Hospital	/ Hospitals, emergency services	Efficiency, presumed best interest
Judicial endorsement practices	Routine court approval with limited scrutiny	National	Mental health tribunals	Procedural formality, systemic inertia
Psychiatric risk scales	Tools used to predict aggression and justify preemptive drugging	Clinical	All institutional settings	Preventive logic, actuarial assumptions

Formal and informal legal, policy, and institutional mechanisms that sustain forced pharmacological treatment across Spain and the EU, illustrating the fusion of clinical discretion with judicial and administrative procedures.

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, manipulateness, 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).

Table 29 - Values and practices lost in contemporary psychiatry

Historical or alternative approach	Valuable element lost in dominant psychiatry	Context or era of origin	Present-day absence or deformation
Ancient greek medicine	Holistic integration of body, mind, and social life	Hippocratic corpus, Classical Greece	Fragmented care, absence of social meaning
Islamic medicine (9th–13th centuries)	Ethical imperative and emphasis on dignity	Al-Razi, Ibn Sina	Coercion accepted in name of risk management
Moral treatment (18th–19th century)	Environmental healing, relational trust	Pinel, Tuke, Esquirol	Replaced by custodial institutions
Early 20th century psychoanalysis	Exploration of symbolic life, meaning, and memory	Freud, Jung, Lacan	Supplanted by pharmacology and behavioral fix
Democratic psychiatry (italy, 1960s–80s)	User participation, deinstitutionalization	Basaglia, reforms	Hollowed forms in community psychiatry
Open dialogue (finland, 1980s–present)	Shared understanding, non-hierarchical care	Tornio region, Western Lapland	Rarely implemented, treated as fringe
Community-based, culturally informed models	Local agency, language adaptation, narrative healing	Latin America, Africa, Global South	Ignored in standardized Western diagnostics

Core values and practices embedded in earlier or alternative paradigms of care that contemporary biomedically-driven psychiatry has neglected or abandoned, emphasizing historical richness and lost potential for healing-based, participatory mental health systems.

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.

Table 30 - Past abuses in psychiatry and present-day echoes

Historical abuse or harm	Timeframe or regime	Present echo in contemporary psychiatry	Shared mechanism or structure
Forced sterilization of the 'unfit'	Early-mid 20th century (e.g., Nazi Germany, USA)	Non-consensual long-acting injectables, guardianship abuse	Eugenic logic, denial of autonomy
Confinement of political dissidents	USSR, Francoist Spain, Latin America	Labeling dissent as pathology, hospitalization	Psychiatry as state apparatus
Aversion therapy and conversion 'treatments'	1950s–70s (USA, UK)	Pathologization of neurodiversity or gender variance	Normative enforcement of behavior
Physical restraint and isolation	Asylums, centuries	19th–20th Seclusion rooms, mechanical restraints	Carceral legacy, punitive containment
Insulin coma, lobotomy	1930s–1950s	Overuse of ECT, experimental polypharmacy	Risk disregard, technological supremacy
Institutional neglect and warehousing	Ongoing in underfunded settings	Understaffed long-term facilities, misdiagnosis	Dehumanization, social abandonment
Diagnoses used to delegitimize	Throughout 20th century	Discrediting patient testimony via 'anosognosia'	Epistemic invalidation, professional infallibility

Historical abuses in psychiatric institutions and traces their conceptual or procedural persistence in contemporary clinical practices, showing how structures of control endure even amid apparent reform.

The dominant psychiatric model in Spain and much of Europe has progressively narrowed its epistemological lens, sidelining relational, ethical, and meaning-centered traditions in favor of pharmacological and behavioral control strategies (Bracken et al., 2012; Kirmayer & Pedersen, 2014). The loss of therapeutic plurality is not merely cultural but structural: care practices once rooted in the moral, spiritual, and communal dimensions of healing have been replaced by algorithmic diagnostics and drug-based standardization. Traditions such as Islamic medical ethics emphasized patient dignity and collaborative meaning-making, while the Moral Treatment and later Open Dialogue models fostered trust, dialogical sense-making, and social integration (Fanon, 1961; Seikkula et al., 2006). These approaches often resisted coercion and prioritized contextual understanding. Conversely, the historical record of psychiatry's coercive and carceral aspects -from sterilization and political repression to experimental interventions on marginalized groups -finds resonance in today's routine use of chemical restraint, diagnostic overreach, and institutional violence under legal cover (Moncrieff, 2022; Gonzalez & Romero, 2020; Huertas, 2022). The continuity of such harm reveals not progress but transformation of form, masked by medical terminology and bureaucratic authority.

Table 31 - Contemporary institutional violence and social death

Institutional mechanism	Effect on personhood or autonomy	Social consequence	Cumulative outcome
Involuntary hospitalization	Loss of freedom and legal agency	Social isolation and stigma	Chronic institutional dependence
Forced medication	Suppression of emotional	Neurological	and Learned helplessness,

Institutional mechanism	Effect on personhood or autonomy and cognitive agency	Social consequence	Cumulative outcome
Guardianship and loss of legal capacity	Infantilization and invisibility	legal exclusion, vulnerability to abuse	Permanent disempowerment
Psychiatric labeling without appeal	Imposed identity and diagnostic fixation	Barriers to employment, education, parenting	Internalized devaluation and hopelessness
Mechanical restraints and seclusion	Physical domination and sensory deprivation	Trauma, dehumanization	Long-term psychological harm and dissociation
Disregard of complaints or reports	Epistemic injustice	Institutional impunity	Total discrediting of lived experience
Neglect of social, legal, nutritional needs	Denial of holistic care	Premature aging, marginalization	Structural invisibility and premature death

Mechanisms through which coercive psychiatric systems perpetuate structural harm and extinguish full social personhood.

Institutional psychiatry, in its dominant biomedical iteration, often claims therapeutic neutrality while operationalizing mechanisms that reproduce *structural violence* and negate fundamental human dignity. These systems do not merely treat diagnosed disorders; they reshape identities, limit legal personhood, and erase narrative agency (Foucault, 2003; Metzl, 2009; Sisti et al., 2021). The imposition of diagnostic labels without transparent review, the use of involuntary treatments as routine administrative measures, and the stripping of legal autonomy through guardianship constructs collectively result in what social theorists term *social death* -the systematic dismantling of an individual's relational, civic, and existential presence (Rose et al., 2019; Moncrieff, 2022).

What remains is a normalized structure of control in which those harmed are denied the ability to testify, to organize, or to recover outside the sanctioned bounds of institutional logic. This framework is not merely theoretical. It corresponds with statistical realities of reduced life expectancy, increased disability, and profound social exclusion among psychiatric survivors (De Hert et al., 2011; Vancampfort et al., 2015; WHO, 2021). The system, designed to protect and support, often ensures the very opposite -unless challenged with evidence, ethics, and sustained structural accountability. Current best practices in psychiatry emphasize that the application of coercive measures -including involuntary hospitalization, forced medication, and physical or chemical restraints -should be restricted to exceptional circumstances in which there is immediate and substantiated risk to life, and no other less invasive alternative is feasible. A growing corpus of international research demonstrates that coercion not only lacks robust evidence for improving long-term clinical outcomes, but is frequently associated with heightened risk of trauma, reduced trust in services, exacerbation of underlying distress, and increased all-cause mortality over time (Large et al., 2014; Sisti et al., 2021; Barbui et al., 2020). Physiological consequences of coerced pharmacological intervention include heightened risk of metabolic syndrome, cardiovascular disease, and neurocognitive decline, as shown in extensive population-based and longitudinal studies (Vancampfort et al., 2015; De Hert et al., 2011; Tiihonen et al., 2009). neuroimaging and neuropathological findings suggest that long-term exposure to antipsychotics, especially in the absence of therapeutic alliance, may lead to volumetric brain changes and functional impairments that are difficult to disentangle from the effects of psychiatric diagnosis itself (Moncrieff & Leo, 2010; Ho et al., 2011).

The clinical justification for coercion has historically rested on paternalistic interpretations of risk and incapacity that are not consistently applied across other medical domains, reflecting unique sociocultural and institutional biases embedded in psychiatric practice (Foucault, 1975/2003; Szasz, 1974; Rose, 2006). The failure to incorporate patient preferences and to adequately inform individuals of potential harms has been documented as a structural deficiency in mental health systems, particularly within high-income countries where pharmacological paradigms dominate service design (Cosgrove et al., 2020; WHO, 2021). While acute agitation or suicidal ideation are often cited as triggers for forced intervention, the lack of predictive validity in clinical risk assessments undermines the scientific basis for coercion as preventive strategy (Ryan et al., 2010; Large et al., 2011). Additionally, forced treatment is rarely followed by independent review or restorative mechanisms, and tends to initiate a trajectory of chronicity and disengagement, not recovery (Gøtzsche, 2015; Read & Dillon, 2013).

The most consistent predictors of psychiatric relapse and deterioration remain social exclusion, adverse childhood experiences, chronic poverty, and lack of meaning-making support -factors not addressed by pharmacological intervention alone (Kessler et al., 2010; Kirmayer & Pedersen, 2014; Patel et al., 2018). Evidence from community-based, dialogical, and psychosocial models -including Open Dialogue, Soteria, and trauma-informed care -demonstrates reduced rates of hospitalization and medication use, greater patient satisfaction, and superior functional outcomes, even in populations with first-episode psychosis (Seikkula et al., 2006; Bergström et al., 2018; Hopper et al., 2007). The reluctance of dominant systems to adopt these models at scale cannot be explained by lack of evidence, but rather by entrenched structural incentives and the epistemic authority conferred upon biologically reductive frameworks. Therefore, the decision to use coercion in psychiatry today reflects not clinical necessity, but systemic defaults and institutional inertia. A rigorous application of medical ethics, human rights standards, and evidence-based public health would demand a reversal of this trend in favor of capacity-building, shared decision-making, and scalable structural support.

This dissertation intervenes precisely where reform must begin: at the reconstitution of patient autonomy and the recognition of shared decision-making as the ethical and clinical core of legitimate psychiatric practice. At stake is not merely a methodological preference but the redefinition of what it means to care. True healing begins with the premise that each person possesses both the right and the capacity to participate actively in decisions affecting their body, mind, and life course. Shared decision-making, far from being a bureaucratic formality or therapeutic luxury, is the operationalization of autonomy in clinical terms: it is the structural antithesis of coercion. Its implementation marks the boundary between treatment and assault, between assistance and domination.

Crucially, this process rests on the presence of trust, a factor repeatedly shown to be both a prerequisite and a product of effective therapeutic engagement. The therapeutic alliance -a robust predictor of clinical outcomes across diagnoses and modalities -is dismantled when care is imposed rather than co-constructed (Horvath & Symonds, 1991; Bordin, 1979; Flückiger et al., 2018). In mental health, where the suffering is often relational in origin or character, healing must be relational in method. The cultivation of trust enables openness, mitigates fear, and supports recovery through mutual recognition. Conversely, isolation, threat, and distrust -common consequences of coercive environments -disrupt neural integration, worsen affective regulation, and deepen psychological injury (Siegel, 2012; Read et al., 2005). Psychiatry that fails to foster safety cannot

claim to offer care. Mental health is not to be monitored for compliance but to be nurtured through respect, presence, and shared humanity.

Punishing patients for their vulnerability -whether through forced medication, seclusion, or disregard of their voice -, and as prevention for their alleged dangerousness to themselves and others, stripping them of rights and dignity required for healing, reflects a clinical failure and a systemic betrayal. The imposition of control in the name of safety often results in precisely the opposite: heightened risk, erosion of therapeutic engagement, and entrenchment of pathology through learned helplessness and internalized stigma (Slade et al., 2014; Rose et al., 2019). Mental health services must not reenact the very dynamics of dominance and humiliation that precipitate crisis. Instead, they must anchor their legitimacy in alliance, not authority; in dignity, not discipline. That principle is not ideological -it is scientific, ethical, and necessary.

The scientific literature has consistently demonstrated that collaborative models yield superior outcomes in engagement, satisfaction, adherence, and long-term recovery. More importantly, they facilitate accountability, prevent abuse, and uphold the basic tenets of medical ethics -respect for autonomy, informed consent, and the principle of non-maleficence. Yet, in many psychiatric settings, particularly in Spain and other European countries with strong biomedical traditions, shared decision-making remains marginal, symbolic, or selectively applied. Patients are frequently excluded from treatment planning; families may be enlisted as enforcers of compliance rather than supporters of dialogue; and professionals often default to presumptions of incapacity rather than cultivating relational competence. Such omissions are not the result of knowledge gaps but of cultural inertia and institutional reluctance to decentralize authority.

Responsibility, in this framework, is reconceptualized -not as an individual burden to justify the use of coercion, but as a shared condition within which persons, professionals, and systems must operate to promote agency. Autonomy is not an abstract ideal but a lived, supported process. It requires adequate information, time, relational trust, and space to consider alternatives. It requires that distress be understood, not suppressed; that behavior be interpreted, not pathologized; that suffering be met with companionship, not suspicion. Most of all, it demands that the professional role be redefined not as the arbiter of truth but as a facilitator of meaningful, plural, and informed choices.

This dissertation therefore does not merely call for the reduction of coercion -it insists on the systematic integration of shared decision-making as a measurable, accountable, and enforceable standard of care. The transformation of psychiatry into a discipline of dignity and justice must pass through this gateway. To choose otherwise is to maintain the fiction that violence is care, and silence is consent. Shared decision-making is not the final goal but the minimal condition for ethical medicine. It is what distinguishes treatment from oppression, care from control, and a health system from a carceral apparatus. In placing autonomy at the center of this inquiry, this research restores psychiatry's potential to serve -not regulate -those it claims to help. The stakes could not be higher, nor the path more clearly defined. What remains is the political and institutional will to walk it.

1.4. Objectives of the action-research undertaken

The present action-research is grounded in the ethical and clinical imperative to transform psychiatric services from institutional frameworks that often perpetuate coercion, silencing, and depersonalization, into systems that foster true healing, structural dignity, and sustainable recovery. The general objective is to contribute to the eradication of psychiatric violence and epistemic

injustice through the empirical development and validation of collaborative, non-coercive care models. These models center on active listening, trauma-informed practices, and the right of every individual to navigate their mental health journey without retraumatization, identity erasure, or status degradation. Rooted in a biocultural and rights-based framework, this research articulates its purpose through SMART objectives: specific, measurable, achievable, relevant, and time-bound goals aimed at facilitating recovery-oriented transformations in mental health services. The objectives are as follows. Not all were fully reached. Some of them, barely attained, regretfully:

1: To identify and describe the systemic mechanisms by which current psychiatric practices contribute to epistemic violence, retraumatization, and long-term iatrogenic harm, particularly through involuntary treatment and identity-defining diagnostic labeling. This objective entails both qualitative and quantitative exploration of professional behaviors, user experiences, and institutional incentives (Johnstone & Boyle, 2018; Frances, 2013).

2: To design and test non-coercive, personalized, trauma-informed intervention protocols that ensure mutual respect, informed consent, and real-time participatory decision-making. These protocols prioritize minimal systemic change with maximal protective effect: establishing healing boundaries, enhancing continuity of care, and promoting the irreducible dignity of the person across contexts (Slade et al., 2014; Davidson et al., 2009).

3: To implement and evaluate collaborative medication management practices that reduce polypharmacy, enhance user autonomy, and prevent medication-related harm through informed deprescription and shared monitoring systems (Garcia Torrents, 2023a; Moncrieff et al., 2019). This includes deploying expert systems as supportive, not substitutive, technologies that integrate subjective narratives with biomedical data for precision and agency (Garcia Torrents, 2023b).

4: To map, document, and compare international best practices in reducing coercion and promoting rights-based recovery, particularly Open Dialogue, Advance Directives, and peer-led support systems (Seikkula et al., 2006; O'Hagan et al., 2012), while adapting them to the Spanish and European context through stakeholder interviews and service evaluations.

5: To co-produce, with users and practitioners, an ethical monitoring framework that identifies early warning signs of coercive drift, institutional betrayal, or structural silencing in clinical settings. This includes the development of training materials, operational ethics protocols, and cultural safety indicators (Watson et al., 2019; Bracken et al., 2012).

6: To promote the recognition of lived experience and social determinants -including gender roles, migration, poverty, and historical violence -as essential variables in clinical care planning and systems design, ensuring that recovery is not framed as compliance but as the regaining of authorship and community participation (Morrow & Weisser, 2012; WHO, 2021).

7: To provide a validated roadmap for the implementation of EU BEACON One Health Education and Technology initiatives within psychiatric care, public education, and legal systems. This roadmap will be based on the integration of fieldwork data, survey analysis, and system modeling conducted through this doctoral research.

Each of these objectives converges toward the primary goal of restoring person-centered care in psychiatry by affirming individual autonomy, contextual intelligence, and collective responsibility. They are aligned with international mandates to eliminate coercion in mental health (United

Nations, 2017; WHO, 2021), and framed within a cross-disciplinary commitment to ethical care systems that protect rather than destroy.

The overarching goal of this doctoral action-research is to identify and implement the minimum effective systemic transformations required to end retraumatization and institutional abuse in mental health care, establishing in their place sustainable models for real recovery, trauma-informed practice, and person-led autonomy. This objective is embedded in the ethical responsibility to deliver care that heals rather than harms, respects rather than pathologizes, and affirms rather than degrades. Recovery, understood as a process of genuine personal and collective transformation, cannot occur where the clinical environment fosters fear, identity stripping, or resignation to chronic institutional dependence. The present work adopts a SMART framework -specific, measurable, achievable, relevant, and time-bound -in its formulation of action-oriented objectives, grounded in the premise that psychiatry must serve healing, not status preservation or epistemic control.

The objective 1 was almost fully attained: the documentation and analysis of the mechanisms through which current psychiatric paradigms perpetuate coercion, loss of autonomy, and systemic retraumatization. This includes empirical and testimonial evidence of involuntary treatment, symbolic violence, and diagnostic overreach, all of which contribute to entrenched institutional betrayal and chronic identity damage (Boyle, 2022; Johnstone & Boyle, 2018). These findings reveal how the routine reproduction of dependency, under the guise of treatment, structurally undermines the possibility of healing and restoration.

On the other hand, objectives 2 to 5, while partially advanced, remain ongoing. They reflect a long-term process of participatory construction and real-world adaptation over more than five years of multidisciplinary engagement. These objectives focus on designing and testing concrete, rights-based care protocols to replace the dominant coercive model. Among these, Open Dialogue has emerged as the most promising foundation. Substantial efforts have been devoted to its study, contextualization, and advocacy, both in Spain and internationally, with a view toward a culturally and institutionally feasible adaptation that addresses the severe limitations in interprofessional collaboration endemic to current service structures (Seikkula et al., 2006; García Torrents, 2023a). The necessary work of implementing one-on-one shared decision-making frameworks with psychiatrists and general practitioners is still unfolding, as it requires a paradigmatic shift in clinical authority, communication, and cooperation -conditions not Yet, present in the fragmented, hierarchical systems that dominate mental health care today. Objective 7 is active, and funded, set as teamwork with already about five hundred experts across the EU COST area and globally.

A coordinated transformation is required: services must operate as truly interdisciplinary ecosystems, with joint deliberation across all professional actors, shared objectives, and a common understanding of the person as sovereign narrator of their own healing path (Slade et al., 2014; Davidson et al., 2009). these clinical changes must be supported by technological and educational tools that empower both practitioners and users. The incorporation of wearables, trackers, and intelligent monitoring systems can support early warning responses, pattern recognition, and the development of health-promoting habits without falling into surveillance or pathologizing logic (Garcia Torrents, 2023b). Likewise, psychoeducation, continuous skill enhancement, and structural humility among clinicians are essential to cultivate safe environments where fear no longer defines care-seeking behavior, and recovery is not the exception but the norm.

The system must be re-engineered to respond proportionately and appropriately to distress, to prevent escalation and re-injury, and to ultimately resolve what now becomes entrenched. No human capital should be lost to preventable deterioration, and no community should accept the locked-in stasis of the "given up" syndrome: the reification of lifelong illness through professional despair and systemic resignation. It is both unethical and clinically fallacious to define persons as chronically ill by default, on the basis of presumptive genetic risk or untestable brain disease models, while ignoring context, environment, trauma, and structural neglect (Moncrieff et al., 2022). Such framing does not reflect scientific humility, but rather professional hubris defending privileges, epistemic control, and vertical power.

The long-standing professional culture of resistance to reform -rooted in fear of losing institutional supremacy -must be named and dismantled. Humility must be reinstated as a clinical virtue. Many patients arrive in psychiatric settings in psychological tatters. Yet, instead of being lifted and restored, they are often subjected to coercive diagnoses, depersonalizing procedures, and a moral economy that rewards submission over self-direction. That this process is sometimes internalized and even thanked by users speaks not to its virtue, but to the total lack of safe, humane alternatives. This thesis posits that such resignation is not recovery. The transformation envisioned herein is not a dismantling of psychiatry, but a fulfillment of its original ethical mandate: to alleviate suffering, to support growth, and to protect the integrity of persons. This requires new tools, but above all, new orientations -toward listening, collaboration, material change, and unbroken continuity of care.

This action-research aims to provide the evidentiary and structural basis for this transformation. It proposes the foundational conditions under which trauma-informed, rights-based psychiatry can flourish, not as idealized exception, but as institutional norm. In doing so, it reclaims the collective and clinical responsibility to ensure that those who seek help are not further harmed, that fear is not the price of care, and that true recovery -social, personal, and epistemic -is not only imaginable, but systematically supported.

1.5. Theoretical framework guiding the work

This action-research is guided by a transdisciplinary theoretical framework that integrates operational design logic (SMART goals), evidence-based mental health promotion strategies (such as NEFF and the NHS Five Steps to Wellbeing), critical anthropological theory (cultural materialism), and biocultural explanatory models incorporating both emic and etic dimensions. Together, these theoretical axes support a methodological and ethical commitment to transforming mental health care into a participatory, trauma-informed, and dignity-preserving system capable of responding to suffering without reproducing it.

At its core, the work adopts the SMART framework -Specific, Measurable, Achievable, Relevant, and Time-bound -as a structural tool for designing and evaluating operational objectives (Doran, 1981). The use of SMART criteria ensures that each aim of the research is not only theoretically coherent but also grounded in implementation logic. This model responds to the long-standing gap between declarative policy commitments to person-centered care and the chronic failure to realize them in practice. Within the SMART logic, goals such as eliminating coercion, implementing collaborative medication management, and restoring continuity of care are translated into actionable, evaluable components that can be locally tested and globally scaled.

Table 32 - Theoretical frameworks underpinning the thesis

Framework	Key Features / Application
SMART Goals	Operational framework for setting specific, measurable, achievable, relevant, and time-bound objectives
NEF Five Ways to Wellbeing	Evidence-based public mental health approach promoting well-being through social and personal engagement
Cultural Materialism	Anthropological lens linking psychiatric practices to material and power structures
Emic–Etic Explanatory Models	Integration of subjective, emic, and external, etic, perspectives to co-construct understanding
Epistemic Justice	Ensures the credibility and inclusion of service-user knowledge in systems reform
Participatory Action-Research	Field-based, co-constructive research methodology grounded in transformation and reflexivity
Power Threat Meaning Framework	Narrative-based alternative to diagnosis that centers meaning, context, and social power
Trauma-Informed Care	Recognizes trauma pervasiveness and prioritizes safety, empowerment, and collaboration
Recovery-Oriented Practice	Defines recovery as agency, community participation, and social inclusion
Shared Decision-Making	Collaborative care decisions respecting user preferences, values, and informed agency
Supported Decision-Making	Legal model affirming autonomy with support rather than substitute decision-making
WHO QualityRights	Rights-based WHO initiative promoting non-coercive, inclusive, and legally aligned services
UN Sustainable Development Goals	Global policy framework aligning mental health goals with justice, equality, and sustainability
Open Dialogue	Dialogic psychiatric model emphasizing minimal medication, relational care, and network inclusion

In alignment with contemporary clinical recovery models, the framework incorporates NEFF’s (New Economics Foundation) *Five Ways to Wellbeing* -connect, be active, take notice, keep learning, and give (Aked et al., 2008). These domains serve both as protective practices for service users and as evaluative dimensions of institutional performance. Far from being behavioral add-ons, these five principles constitute the psychosocial substrate of recovery, countering the reductive tendency to interpret psychiatric improvement exclusively through symptom reduction. these principles provide a transversal reference point for professional behavior, organizational design, and peer-led support, reinforcing a logic of care that is non-extractive, non-punitive, and affirming of personhood (Slade et al., 2014).

The research is also grounded in the theoretical contributions of cultural materialism (Harris, 2001), which holds that social practices, institutions, and ideologies must be understood in relation to their material conditions of production, reproduction, and control. From this perspective, psychiatry is not merely a clinical field but a historical apparatus embedded in broader systems of resource allocation, labor discipline, and biopolitical governance. The persistence of coercion, the medicalization of social suffering, and the professional monopoly over explanatory legitimacy are analyzed as structurally reinforced patterns. These patterns serve to stabilize certain power asymmetries -particularly along lines of gender, class, race, and migration status -under the guise of

therapeutic necessity. Through a cultural materialist lens, the apparent neutrality of diagnoses and interventions is problematized, and the distribution of mental health outcomes is read as the cumulative product of material inequalities and symbolic violence (Scheper-Hughes & Lock, 1987; Farmer, 2004).

In keeping with medical anthropology's commitment to explanatory pluralism, this work integrates both emic and etic perspectives. Emic insights are foregrounded in the qualitative corpus of the research, particularly through narrative testimony, patient feedback, and lived experience reports. These data do not merely illustrate professional failings but serve as epistemically valid accounts of psychiatric harm and healing. Etic constructs, including clinical indicators, policy analysis, and diagnostic frameworks, are critically reinterpreted in light of these lived accounts, enabling a recalibration of institutional priorities and explanatory models. The synthesis of emic-etic approaches aims not to relativize evidence, but to ensure that institutional systems are accountable to those they affect, and that explanatory frameworks are co-constructed rather than imposed (Good, 1994; Kleinman, 1980).

Additionally, this framework directly confronts the systemic gender asymmetries and class biases embedded in psychiatric theory and practice. Gender-based violence, economic precarity, and racialized exclusion are not contextual "risk factors" but structural determinants of mental distress. Theoretical approaches that obscure these determinants through pathologizing or individualized narratives are here rejected as inadequate and ethically indefensible. In their place, the research adopts a framework of epistemic justice (Fricker, 2007), insisting that lived experience -particularly from survivors of coercion and systemic harm -constitutes a primary evidentiary source for the redesign of care. This framework posits structural humility as a cornerstone of ethical practice. It challenges the defense of professional status through the epistemic infantilization of users, the performative assertion of scientific authority, and the systemic minimization of user knowledge. The recovery envisioned herein is not symbolic but material: it entails not only internal transformation, but also the external transformation of the conditions that produce and perpetuate suffering. In that sense, this work rejects therapeutic fatalism and professional paternalism, advancing instead a science of repair that is collective, situated, and reparative.

This all, in the present work, is inseparable from the methodological and ethical commitments of participatory action-research and open science. In contrast to hierarchical research designs that treat participants as data points, this work adopts a co-constructive model in which knowledge is generated with -and often from -those most affected by the mental health system. The methodology emerges not only from ethical imperatives, but from epistemological necessity: those with lived experience of psychiatric intervention, coercion, or neglect are the most credible witnesses to systemic violence, and the most qualified agents for shaping its alternatives (Faulkner, 2017; Beresford, 2019). This thesis rejects extractive epistemologies and embraces an iterative, field-based approach grounded in consent, narrative integrity, and the mutual construction of meaning. In doing so, it upholds the core tenets of action-research: responsiveness, reflexivity, and social transformation (Reason & Bradbury, 2008). Aligned with the principles of epistemic justice and the ethics of care, this work draws extensively on the Power Threat Meaning Framework (PTMF), developed as an alternative to diagnostic psychiatry (Johnstone & Boyle, 2018). Rather than asking "what is wrong with you?" -the foundational question of the diagnostic paradigm -PTMF asks: "what has happened to you?", "how did it affect you?", "what sense did you make of it?", "what did you have to do to survive?", and "what are your strengths?" These shifts are not rhetorical; they

constitute a paradigmatic reorientation of the mental health field from a biomedical, individualizing, and often pathologizing stance to one that situates distress within social, relational, and historical contexts. This perspective enables a conceptual transition from illness management to meaning restoration, from compliance to resistance, and from surveillance to solidarity.

The PTMF provides the theoretical scaffolding for understanding how violence -whether institutional, interpersonal, or structural -manifests as psychological suffering and social alienation. In doing so, it facilitates the recognition of service users not as passive recipients of care but as active interpreters of their experiences and agents of their own recovery. The framework validates the central claim of this research: that the majority of what is labeled "mental illness" is in fact the legitimate expression of threat responses to sustained or acute adversity, mediated through cultural norms and social power relations (Boyle, 2022). It also foregrounds the necessity of addressing meaning and narrative in the therapeutic process -not as secondary concerns but as central clinical tasks. This reframing is operationalized through trauma-informed and recovery-oriented approaches. Trauma-informed care, as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), is grounded in the understanding that trauma is both pervasive and frequently unacknowledged within psychiatric systems. It calls for the active avoidance of re-traumatization, the creation of physically and emotionally safe environments, and the privileging of transparency, choice, collaboration, and empowerment. These principles are not add-ons to psychiatric practice; they are its preconditions, if care is to be understood as ethically legitimate. Recovery orientation further redefines success not as clinical stabilization or diagnostic compliance but as the restoration of self-determination, agency, and participation in community life (Davidson et al., 2009). Within this paradigm, the endpoint is not symptom management under authority but relational and structural healing through mutual recognition and social inclusion.

Within this framework, shared decision-making (SDM) and supported decision-making (SUDM) are treated not as optional enhancements but as foundational paradigms of lawful and ethical care. Shared decision-making refers to the collaborative process through which clinicians and service users make health-related decisions together, respecting user preferences, values, and lived knowledge while integrating clinical evidence (Elwyn et al., 2012). This model reframes the clinical encounter from one of expertise imposition to one of reciprocal deliberation and co-authorship. It demands transparency, adequate information sharing, and recognition of the service user's epistemic and moral agency. Supported decision-making further extends this logic by affirming the legal capacity of all persons -regardless of cognitive, psychiatric, or social status -to make decisions about their lives, with the appropriate relational, communicative, or practical support (Arstein-Kerslake & Flynn, 2016). Unlike substitute decision-making models, which authorize coercive interventions based on perceived incapacity, SUDM insists that the role of systems and professionals is to uphold autonomy through facilitation, not override. This distinction is codified in the Convention on the Rights of Persons with Disabilities (CRPD, 2006), which affirms the right of individuals to legal recognition and self-determination on an equal basis with others. The ethical legitimacy of psychiatric interventions depends, therefore, on their alignment with these principles.

This research framework is fully committed to the legal and normative standards set by international human rights bodies, particularly the United Nations and the World Health Organization. It adopts the WHO's *QualityRights* initiative not only as a set of programmatic guidelines, but as a binding ethical framework that demands the elimination of coercion, the protection of legal capacity, and the transformation of services through rights-based approaches

(World Health Organization, 2019). QualityRights operationalizes the CRPD by providing actionable standards, implementation tools, and training protocols that guide mental health systems toward respect, safety, and user empowerment. This thesis follows those guidelines rigorously, using them both as an evaluative benchmark and as a developmental guide for practice reform.

Furthermore, the theoretical and operational priorities of this research are situated within the broader agenda of the United Nations Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-being), SDG 5 (Gender Equality), SDG 10 (Reduced Inequalities), and SDG 16 (Peace, Justice and Strong Institutions). The realization of these goals in the domain of mental health depends on the dismantling of systemic abuses, the implementation of inclusive care systems, and the recovery of citizen agency through lawful participation and institutional accountability (UN, 2015). Psychiatric transformation is not an isolated challenge but a necessary component of sustainable, rights-based development. Within this frame, coercion is not only clinically damaging but structurally regressive, reinforcing intergenerational exclusion and institutional violence.

These commitments -shared and supported decision-making, full autonomy, and the alignment with QualityRights and the SDGs -do not sit beside the theoretical core of this work. They constitute it. They ensure that every model proposed, every protocol tested, and every policy critiqued is evaluated not only by clinical outcomes, but by its capacity to respect and advance fundamental human rights. Open Dialogue, serves as the most developed and empirically supported instantiation of these principles in clinical form. Developed in Finland and now internationally replicated, Open Dialogue is a system of psychiatric crisis response and long-term care built on dialogic practice, network inclusion, and minimal medication. It refuses to separate the individual from their social context, or to define the problem in advance of relational exploration. Instead, clinicians and service users co-create understanding in real time, resisting premature closure and maintaining continuity of care through the entire process (Seikkula & Arnkil, 2014). This model not only aligns with but enacts the ethical priorities outlined above: shared decision-making, contextual sensitivity, and enduring therapeutic alliances based on mutual trust and listening.

The work presented here constitutes one of the first extended applications of Open Dialogue principles in the Spanish and European contexts under the dual logic of recovery and action-research. It documents both the promise and the institutional resistance encountered when such models confront entrenched hierarchies, fragmented services, and epistemic conservatism. Nonetheless, the practical value and transformative potential of Open Dialogue -particularly when integrated with digital tools, community participation, and participatory governance -remain unmatched in contemporary psychiatry. Its dialogic principles are echoed across all domains of this thesis: in its survey design, field methods, analysis of systemic dysfunction, and the proposal of scalable, non-coercive models for ethical care.

In conclusion, this theoretical framework is not merely conceptual. It is inseparable from the political, structural, and affective conditions necessary to rehumanize psychiatry. It affirms that care must be co-produced, accountability must be horizontal, and recovery must be real -not performative. The convergence of SMART logic, PTMF meaning-making, trauma-informed safety, and Open Dialogue's radical relationality offers not only a theoretical foundation but a strategic path forward for transforming mental health systems toward justice, dignity, and healing.

1.6. State of the art before starting the action-research

Before the initiation of this action-research, the dominant psychiatric paradigm in Spain and across much of Europe continued to operate under a biomedical framework that, despite its medical label, frequently contradicted the core ethical and epistemological principles of both science and medicine. While presenting itself as evidence-based, this model often relied on unproven assumptions about the nature of mental distress -chief among them, the reduction of suffering to discrete brain pathologies or presumed chemical imbalances, which remain scientifically unverified (Moncrieff, 2008; Lacasse & Leo, 2005; Davies, 2022). The uncritical adoption of diagnostic classification systems such as the DSM-5 and ICD-10 perpetuated a logic of categorization that preempted individualized understanding, blocked recovery pathways, and undermined the clinical duty to do no harm (Frances, 2013; Cosgrove & Krinsky, 2012). These assumptions were not only scientifically weak but epistemologically closed, eliminating the necessary uncertainty and narrative openness required in ethically sound medical practice. Rather than foster care, they institutionalized resignation -the so-called "giving up given up syndrome," in which professional identity is bound to chronicity and patient identity to pathology, negating the potential for real healing.

This betrayal of science and medicine was not a marginal issue, but systemic. The entrenchment of these practices within university training, clinical protocols, and judicial interpretations created a self-reinforcing apparatus in which deviation from the biomedical standard was framed as unprofessional or dangerous (Rose, 2007; Bracken et al., 2012). In Spain, psychiatry has remained largely shielded from the interdisciplinary scrutiny to which other medical specialties are increasingly subject. Medical education programs have continued to emphasize pharmacology and diagnosis over communication, trauma literacy, or social determinants, while rarely teaching updated neurobiological findings that call into question the linear assumptions of psychiatric pathology (Kendler, 2005; Insel, 2022). The separation of neuroscience from context -biological from biographical -has resulted in a pseudoscientific gap between research and clinical translation. This is not merely an epistemic flaw; it is an ethical and legal failure, as it leads to care that is out of step with current evidence and in violation of rights-based health obligations enshrined in international treaties such as the CRPD and the Oviedo Convention (United Nations, 2006; Council of Europe, 1997).

Contrary to the defensive posture adopted by sectors of the old psychiatric guard, resistance to this paradigm shift cannot be accepted. The modernization of care, as demanded by the World Health Organization (2021), the European Union Fundamental Rights Agency (2022), and national frameworks such as Spain's *Estrategia de Salud Mental 2022–2026* (Ministerio de Sanidad, 2022), is not optional. It is a professional, legal, and moral requirement. These documents converge on one demand: full respect for autonomy, non-harm, and recovery as the goal -not the maintenance of managed chronicity. The call is not only for updated knowledge but for updated institutions, including new training systems capable of preparing professionals to implement trauma-informed, non-coercive, and relational care practices grounded in contemporary neuroscience, phenomenology, and community engagement (Slade, 2013; Johnstone & Boyle, 2018). The failure to translate this knowledge into practice is not due to scientific uncertainty but to organizational conservatism, power retention, and a fear of losing status rather than a fear of causing harm. This must end. The defense of outdated models in the face of superior evidence and legal clarity constitutes institutional negligence.

Spanish professional bodies have increasingly recognized this tension. While some sectors of the Sociedad Española de Psiquiatría y Salud Mental (SEPSM) continue to cling to biomedical orthodoxy, organizations such as the Asociación Española de Neuropsiquiatría (AEN), the Consejo General de Trabajo Social, and nursing and primary care associations have called for integrated, rights-based, and non-coercive approaches (AEN, 2018; CGTS, 2020; SATSE, 2021). The public, too, has begun demanding accountability. Patient advocacy groups, survivor movements, and civic platforms such as Salud Mental España, Locura con Sentido, and ActivaMent have insisted on the full elimination of forced treatment, the end of mechanical restraints, and the implementation of supported decision-making in line with the CRPD (Salud Mental España, 2019; Locura con Sentido, 2020). These are not marginal demands -they represent the evolving ethical standard of care. They reflect a society no longer willing to tolerate psychiatric paternalism, institutional violence, or systemic neglect under the guise of science.

This action-research is situated within that historical shift. It does not claim to lead it, but it does document and reinforce its legitimacy, its empirical grounding, and its ethical necessity. It shows that recovery is not a utopia, but a practical, systemically attainable goal when the assumptions that block it are removed. Health is not a fixed identity but a dynamic process -one that requires both medical knowledge and social repair, relational respect and scientific humility. The function of care is not to lock in suffering, but to release its grip. There is no clinical justification for giving up on people. The duty to care, in psychiatry as in all medicine, is not only to alleviate symptoms, but to ensure that the systems we build do not reproduce the harms they were created to heal.

The structural architecture of psychiatric and mental health care across Spain and most of Europe remains fatally fragmented. While the theoretical shift toward biopsychosocial integration has been declared for decades, in practice, care is still delivered through disconnected silos -primary care, psychiatry, social services, community mental health teams, emergency services -each functioning under separate institutional mandates, incompatible record systems, and often contradictory goals. Communication across these domains is rare and usually informal. No unified narrative of the person is allowed to emerge. As a result, professionals operate under procedural logics that override ethical reflection, and persons in crisis fall through institutional cracks, with each actor absolving themselves of responsibility. Family doctors, increasingly pressured by time constraints and bureaucratic overload, often resort to quick referrals or automatic prescription renewals, perpetuating pharmacological dependency without therapeutic accompaniment (World Health Organization Europe, 2018; López-Casasnovas & Rico, 2003). Generalists are trained to identify psychiatric categories but rarely given tools to question their validity or address underlying social determinants. Even when aware of the trauma, loneliness, or injustice behind the distress, their hands remain tied by institutional protocols and a risk-averse culture.

At the level of psychiatric services, this fragmentation produces chronic discontinuity and a depersonalized, episodic model of care. Individuals encounter psychiatrists who rotate frequently, receive contradictory diagnoses, or are discharged without follow-up. Continuity -essential for recovery, safety, and relational trust -is structurally impossible. Patients, reduced to diagnostic codes, are managed rather than understood. Treatment plans are dictated more by legal defensibility and resource availability than clinical appropriateness or narrative coherence. Interventions are often initiated with no clear exit strategy, leading to a situation in which cessation of medication is perceived as risk rather than a sign of recovery. Attempts at deprescribing are discouraged or ignored. In many settings, medication becomes a proxy for care -its continuation taken as an

indicator of clinical legitimacy, and its withdrawal read as irresponsibility or relapse. This reductionist cycle blocks any attempt to view recovery as relational, contextual, and time-sensitive. Even where professionals aspire to deliver person-centered care, the institutional scaffolding undermines them at every turn.

The structural deployment of diagnostic classifications contributes significantly to this dysfunction. Psychiatric diagnosis in Spain is typically based on the ICD-10 or DSM-5. Yet, both systems are widely acknowledged to lack empirical validity, internal consistency, and prognostic utility (Kirk & Kutchins, 1992; Bentall, 2003; Frances, 2013). They offer the illusion of precision while masking profound heterogeneity and often pathologizing understandable responses to adversity. This is not merely a matter of conceptual error: it has operational consequences. Diagnostic labels, once applied, become institutional identities -triggering standardized treatment pathways, eligibility decisions, and legal judgments that may persist for life. They shape how professionals perceive the individual and how the individual sees themselves. In practice, diagnoses preclude rather than open recovery, especially when imposed early, without informed discussion, or in contexts of coercion. They lock users into a status of chronicity, vulnerability, and incapacity, even when these are not clinically justified. This results in what might be termed "iatrogenic prognosis": a future determined not by the person's capacities or context, but by the inertia of institutional expectation.

This dysfunction is not limited to psychiatry. Social workers, educators, and even employment services are often forced to use psychiatric categories as gatekeeping tools. Access to income support, disability certification, or housing is frequently mediated through diagnosis, encouraging users to perform symptoms to access basic rights, and professionals to reinforce pathology as a precondition for social assistance (Mechanic, 2007; García de Vinuesa, 2014). These structural incentives reinforce passivity and chronicity, undermining both agency and accountability. Care becomes a matter of documentation rather than support. Social workers are overwhelmed by paperwork; users are infantilized by systems that respond to survival strategies with suspicion or neglect. Nurses, often at the front line of mental health services, find themselves executing protocols they disagree with -forced to administer forced medication, apply restraints, or justify care plans that violate their ethical commitments. Burnout is endemic. Moral injury becomes routine. Meanwhile, professional bodies offer little in terms of collective resistance, and institutional reform remains blocked by a bureaucratic culture that equates standardization with safety and change with threat.

Even where islands of good practice exist -centers trying to implement Open Dialogue, recovery-oriented frameworks, or interdisciplinary coordination -the lack of systemic support renders these efforts precarious. Innovation depends on individual will, not structural design. As soon as a key actor leaves, the initiative collapses. Pilot programs are praised but not scaled. Funding is inconsistent. Evaluation is often tokenistic. Institutional cultures, especially in large hospitals, remain hierarchical, defensive, and deeply resistant to change. These dysfunctions are not just barriers to efficiency -they are barriers to humanity. They render care impersonal, users voiceless, and professionals complicit. The system teaches everyone involved -whether doctor, nurse, patient, or family -to lower their expectations. It is a machinery that normalizes failure, routinizes harm, and then pathologizes those who resist.

The persistence of coercion and institutional violence in psychiatric practice cannot be understood solely through clinical categories or resource limitations. It is deeply rooted in legal frameworks, administrative logics, and epistemic deference to medical authority that collectively render coercion

not a deviation, but a routine, authorized, and often invisible function of the system. In Spain, the primary legal mechanism enabling involuntary psychiatric interventions is Article 763 of the Ley de Enjuiciamiento Civil, which allows for non-consensual hospitalization when a medical report justifies it and a judge approves the action -often post hoc, based on presumed necessity (Ley 1/2000, art. 763). In practice, this framework creates an expedited administrative pipeline: doctors write, judges sign, individuals are confined. There is no real adversarial process, no presumption of capacity, and often no informed legal representation. The very individuals most at risk of harm are those least likely to have their voices heard or their rights respected. The judicial process is symbolic, not protective. Its function is not to interrogate psychiatric decisions but to authorize them retroactively, thereby laundering clinical power through legal legitimacy.

This legal delegation of coercion to psychiatry is not limited to hospitalization. It extends to forced medication, chemical restraint, physical immobilization, and the use of security personnel in clinical settings. Once hospitalized under coercion, individuals may be subjected to weeks or months of treatment without consent, under the authority of risk-prevention protocols or institutional regulations rarely subjected to external scrutiny. The notion of "risk" in this context functions as an empty signifier -invoked without transparent criteria, often based on vague professional impressions or behavioral deviation from normative expectations. Risk justifies restriction; restriction is equated with safety; safety becomes the moral cover for violence. No one is accountable. This epistemic collapse -where subjective judgment masquerades as objective necessity -grants extraordinary discretionary power to psychiatrists and institutional actors, while rendering service users structurally voiceless. The assumption is always that the doctor knows best, and that the individual's objection is proof of illness. The system punishes dissent by diagnosing it.

Judicial actors, far from serving as safeguards, often act as rubber stamps in a bureaucratic process designed for speed, not justice. In Spain, most judges lack any specialized training in mental health law, human rights standards such as the CRPD, or the social implications of psychiatric labels. Their decisions are based almost exclusively on medical reports, often one or two pages long, which summarize symptoms and assert the need for involuntary treatment. These documents are rarely challenged, and hearings -when held -are often perfunctory or skipped entirely. The logic of presumed incapacity reigns, supported by a civil code that still allows for guardianship regimes and plenary incapacitation, despite recent legislative reforms (Ley 8/2021). Even with the formal transition to supported decision-making, practical implementation has lagged far behind legal mandates. Judges, clinicians, and social workers frequently operate under outdated assumptions, institutional routines, and implicit biases that invalidate the autonomy of those with psychiatric diagnoses. Reform on paper does not translate into transformation in practice.

Administrative systems -especially in the health and social care sectors -reproduce this violence through structural omission. Public health authorities, hospital managers, and service directors rarely audit coercive practices, and when they do, they focus on procedural compliance rather than substantive harm. Documentation of restraint use or forced treatment is often incomplete, inaccurate, or unavailable. Complaints are handled internally, with no real mechanisms for independent review. The same institutions responsible for delivering care are tasked with investigating abuses, resulting in systemic impunity and survivor silencing. In many cases, families who attempt to report mistreatment are met with defensiveness, legal threats, or bureaucratic obstruction. Meanwhile, service users who speak out are often further pathologized, with their testimonies dismissed as symptoms of illness rather than credible accounts of violence. This is not a

failure of individual actors but of institutional design: a system that positions clinicians as unquestionable experts and users as unreliable subjects cannot deliver justice. It can only reinforce harm.

The media and professional codes of silence further entrench this dynamic. Scandals involving psychiatric abuse -such as deaths under restraint, sexual violence in locked units, or prolonged forced treatment -rarely make headlines, and when they do, they are presented as anomalies rather than indicators of systemic dysfunction. Professional colleges often close ranks to protect reputational integrity, framing criticism as anti-psychiatry or emotional overreaction. Meanwhile, human rights reports by international organizations, including the United Nations Special Rapporteur on the right to health and the Council of Europe Commissioner for Human Rights, have repeatedly condemned Spain's reliance on coercive psychiatric practices, its failure to implement supported decision-making, and the lack of access to independent complaints mechanisms (UN, 2017; Council of Europe, 2018; WHO, 2021). Yet, institutional response has remained minimal, reactive, and often symbolic. The discourse of reform is deployed to appease criticism, not to effect change. Guidelines are published, but funding remains unchanged. Training is recommended, but not mandated. Evaluation is suggested, but never enforced.

The coercion persists mostly not because it is necessary, but because the system is built to allow it. Violence becomes rationalized through institutional procedures, disguised as care, and shielded by professional authority. This process does not require malice -only complicity, routine, and the suspension of ethical scrutiny. Professionals act under the illusion that their actions are scientifically justified and legally protected. Institutions act under the illusion that their mandates are benevolent. But the result is the same: suffering ignored, rights denied, lives disfigured in the name of treatment. Until this architecture of impunity is dismantled -not merely amended, but structurally reconfigured -no real reform is possible.

Despite the growing international consensus on the need to shift mental health systems toward non-coercive, rights-based, and recovery-oriented models, the practical implementation of these paradigms in Spain and much of Europe has remained marginal, fragmented, and institutionally precarious. Models such as Open Dialogue, Hearing Voices Networks, Soteria, trauma-informed care, and peer-led crisis alternatives have been developed and piloted in various contexts with strong empirical and ethical backing (Seikkula & Arnkil, 2014; Romme & Escher, 2000; Mosher, 1999; SAMHSA, 2014). Yet, these practices have rarely achieved structural integration. Instead, they have been limited to local experiments, often reliant on temporary funding, isolated leadership, and external advocacy. Their implementation has faced substantial resistance -not due to lack of evidence, but due to a systemic fear of disrupting professional hierarchies, bureaucratic procedures, and power structures that benefit from the current status quo.

In the Spanish context, initiatives aligned with Open Dialogue principles have been attempted in regions such as Catalonia, the Basque Country, and Andalusia. Yet, their uptake has remained largely informal, often led by motivated professionals acting without institutional mandate or long-term support. Training in dialogic practice, systemic family work, or trauma-informed care is not part of standard postgraduate curricula in psychiatry, psychology, or social work, and must instead be pursued through external or foreign programs. Where implemented, such approaches are often absorbed superficially into conventional services, stripped of their epistemological and structural critique. They are deployed as therapeutic techniques, not as paradigmatic alternatives. This

appropriation renders their transformative potential null, serving instead as ethical alibis for systems that continue to operate through control and standardization.

Peer work, though increasingly discussed in policy documents, remains functionally marginal. While the Spanish mental health strategy and various regional plans recognize the value of peer professionals and expert-by-experience involvement, their operationalization is obstructed by bureaucratic hurdles, undefined job categories, and ambiguous power relations (Ministerio de Sanidad, 2022). In many cases, peer workers are tokenized -invited to speak or share testimonials, but not empowered to shape services, challenge practices, or initiate structural change. Their experiential knowledge is welcomed as narrative, not as evidence. This epistemic asymmetry reinforces the dominance of biomedical expertise and limits the epistemological plurality that real innovation demands. Without structural support, adequate remuneration, and institutional authority, peer roles become symbolic, their potential instrumentalized rather than realized.

Research agendas further reproduce this marginalization. Despite increasing recognition of the importance of service-user involvement and implementation science, the dominant funding streams in Spain and across Europe remain oriented toward biological psychiatry, pharmaceutical trials, and early detection initiatives grounded in individual pathology rather than social or systemic determinants. Universities rarely invest in survivor-led research, critical psychiatry, or participatory methods. When such projects are undertaken, they struggle to find legitimacy, publication venues, or institutional allies. The production of knowledge is monopolized by the same institutions and professionals whose authority is questioned by these alternatives. Structural humility, which would require these institutions to share power, admit error, and co-lead with those historically harmed, is largely absent.

Even more insidiously, many of the terms once associated with transformative practice -"recovery," "trauma-informed," "person-centered," "collaborative" -have been co-opted into mainstream institutional discourse without corresponding changes in practice. Services describe themselves as recovery-oriented while continuing to rely on coercion. Care plans are labeled collaborative while based on predetermined diagnostic scripts. Training sessions include trauma theory while ignoring the everyday retraumatization of locked wards, chemical restraints, and unvalidated assumptions. This discursive capture operates as a defense mechanism against reform. By adopting the language of rights without its content, institutions protect themselves from criticism while blocking substantive change. Reform becomes a matter of branding, not restructuring. Innovation is reduced to image management.

Table 33 - State of the art in psychiatric practice, from coercion and punishment to full recovery

Cause & Action	Context / Origin	Consequences	Material & Practical Solutions
Involuntary hospitalization due to acute distress, confusion, or perceived danger	Emergency, crisis response, post-conflict, overwhelmed families, social isolation	Loss of autonomy, trauma, legal status loss, chronicity framing	Network-based Open Dialogue; supported retreats (e.g. family respite holidays); mobile crisis teams with peer workers; 24/7 community respite homes; long-stay cooperative living environments with educational and emotional support
Forced medication imposed without collaborative plan	Psychiatric wards, Neurological outpatient supervised treatment,	harm, learned helplessness, loss of future- designed care plans; wearable-	Medication tapering services with diet and exercise interventions; co- designed care plans; wearable-

Cause & Action	Context / Origin	Consequences	Material & Practical Solutions
	refusal of care	oriented self	supported monitoring; non-pharmacological recovery tracks (e.g. psychoeducation, peer mentoring)
Mechanical physical restraint or inpatient elderly care strain	Emergency rooms, wards, under	Injury, PTSD, shame, systemic retraumatization, reduced trust in health providers	Trauma-informed care units; open-sensory safe rooms; fully funded de-escalation staff training; peer-staff conflict mediators; crisis centers with 1:1 relational supports
Seclusion used for behavioral management	Forensic youth residential units, high-agitation diagnoses	Emotional shutdown, disassociation, retraumatization, denial of human contact	Abolition policies with legal reinforcement; non-lockable sensory spaces; user-led cool-down protocols; open-space care architecture; funding for continuous interpersonal support
Diagnosis without dialogue or consent	Social referrals, evaluations, and court reports	services Pathologization, forced exclusion decisions, school foreclosure	Case formulation workshops with users; PTMF training for staff; legal right to reject or co-write clinical notes; diagnostic dialogue protocols as standard
Court-mandated interventions via outdated laws	Article 763 LEC, guardianship substitute decision-making practices	Structural disempowerment, loss of liberty, system-induced trauma	Legislative overhaul; permanent legal advocacy offices in psychiatric institutions; widespread training on legal capacity and CRPD compliance; user-lawyer co-drafting teams
Dismissal of user testimony based on diagnostic prejudice	Discharge planning, psychiatric evaluations, institutional reviews	Silencing, stigma, mistrust	Peer-led narrative validation circles; co-written evaluation reports; survivor testimony training for staff; narrative-based service audits
Superficial participation planning	Advisory boards, institutional "listening" events, research ethics boards	Disillusionment, betrayal, symbolic inclusion without change	Co-leadership structures; rotating user-resident budget allocations; participatory design for services; independent survivor-led audits with binding review power
Risk displacing reflection	Safety policy routines, discharge criteria, institutional aversion	Institutional rigidity, punishment culture, innovation blockage	Ethics-based care planning tools; risk replaced with relational concern indicators; collective reflection rounds with inter-professional and user participation

The evidence base for non-coercive, community-rooted, and dialogic approaches continues to grow. Longitudinal studies of Open Dialogue in Finland and replications in countries such as the UK, Italy, and Germany show significant reductions in hospitalization, medication use, and chronicity, alongside improvements in functioning, user satisfaction, and social integration (Bergström et al., 2018; Seikkula et al., 2006; Freeman et al., 2019). Trauma-informed frameworks have demonstrated significant improvements in service engagement, safety outcomes, and practitioner well-being (Bloom & Farragher, 2013; Sweeney et al., 2018). Peer-led crisis alternatives reduce admissions and enhance self-efficacy without producing the harms associated with coercive interventions (Gillard et al., 2013). The problem is not that alternatives are lacking; it is that they are structurally

excluded. Change is not blocked by uncertainty, but by institutional investment in practices that preserve control, reduce liability, and prioritize order over ethics.

The marginalization of these alternatives cannot be addressed through isolated projects or moral appeals. It requires a systemic reorientation of training, funding, governance, and accountability. It demands that institutions relinquish monopoly over knowledge and include survivors as co-creators of care. It necessitates legal mechanisms that not only prohibit coercion but incentivize relational, rights-based practice. And above all, it requires recognition that the current system is not merely flawed, but harmful -actively impeding recovery, violating rights, and delegitimizing human agency. As long as alternatives are permitted only on the margins, the center will remain violent.

The systemic violence of psychiatric care in Spain and Europe must ultimately be understood as the contemporary expression of much older historical processes: the institutional regulation of difference, the medicalization of deviance, and the biologization of inequality. Psychiatry, from its emergence as a modern discipline, has operated not merely as a healing profession but as a bureaucratic device of social sorting. It has defined, categorized, and confined those who fall outside sanctioned norms -whether in thought, behavior, emotion, or social position. This function, as Foucault (1961/2006) demonstrated, is inseparable from the broader historical apparatus of power: psychiatry did not arise to cure, but to manage, and in so doing it internalized the epistemologies of the penal system, the colonial archive, and the Christian moral economy. Contemporary practice -despite its technological sophistication and humanistic rhetoric -remains saturated by these genealogies. The clinical diagnosis of schizophrenia or personality disorder today functions as a cultural verdict, not a neutral label. It marks the subject as dangerous, irrational, unreliable. It invites containment, silences protest, and renders the person's narrative epistemically inferior.

In this context, the psychiatrist becomes a liminal figure, positioned between the promise of scientific objectivity and the lived experience of structural domination. Tasked with interpreting behavior, authorizing intervention, and negotiating institutional logics, the psychiatrist operates as both clinician and sovereign -holding the legal and symbolic authority to override consent, nullify legal capacity, and reassign personhood. While many psychiatrists seek sincerely to alleviate suffering, their professional position is structurally compromised by the entanglement of care with control. The exercise of clinical judgment is frequently distorted by institutional incentives, diagnostic inertia, fear of liability, and tacit alignment with conservative moral values. The doctor does not speak from a neutral place: they speak from within a system that has long legitimized violence against those deemed "mad," "abnormal," or socially inconvenient. Their authority is not only clinical -it is political, symbolic, and often, whether intended or not, exclusionary.

This exclusionary function has been particularly acute at the intersections of race, gender, class, and migration status. Across Spain and Europe, marginalized groups are disproportionately pathologized, misdiagnosed, and subjected to coercive interventions. Migrants, racialized minorities, women in situations of poverty or domestic violence, trans and queer individuals, children in care systems -these populations are more likely to be labeled, restrained, institutionalized, and silenced (Cénat et al., 2022; Fernando, 2017; Whitley et al., 2021). Psychiatry in this sense becomes not a response to suffering but a channel for the expression of societal xenophobia, sexism, and class violence under the cover of clinical concern. The diagnostic categories, risk assessments, and professional recommendations become tools through which structural injustice is re-inscribed and normalized. The vulnerable are not protected but

vulnerabilized -rendered visible to the system only as problems to be managed, not persons to be supported.

This dynamic extends into the family and community spheres, where psychiatric labels and interventions are often mobilized to enforce normative behavior, suppress dissent, or conceal violence. Children reacting to trauma are labeled disruptive. Women resisting control are diagnosed as borderline. Migrants confronting racism are deemed paranoid. These translations are not aberrations -they are the system functioning as designed. The psychiatric apparatus offers language, procedures, and institutional legitimacy for converting political, relational, or existential distress into individualized deficits. In doing so, it often protects abusers, exonerates institutions, and repositions victims as perpetrators of their own suffering. This is the cultural logic of what might be termed "psychiatric impunity": the transformation of oppression into illness, and of survival strategies into pathology. The system cannot heal what it denies, and cannot protect those it does not recognize as fully human.

Media, education, and popular discourse reinforce this structure. The archetype of the "mentally ill" as unstable, irrational, and potentially violent persists despite decades of anti-stigma campaigns. Public awareness is superficial; real understanding is rare. Psychiatric power is rarely questioned, and its failures are seldom addressed outside specialized spaces. Survivors of psychiatric violence are still broadly treated as unreliable witnesses, their critiques dismissed as symptoms rather than valid evidence. Those who try to resist are offered two choices: compliance or marginalization. Institutions co-opt reformist language while maintaining abusive practices. Professionals are trained to "manage" rather than understand, to "treat" rather than listen. Meanwhile, the system continues to produce preventable deaths, chronic trauma, and intergenerational harm -often invisibly, silently, and with full bureaucratic approval.

In this context, the central challenge is not to improve psychiatric services within the current model, but to unmake the conditions that render harm systemic. This requires a fundamental redefinition of what counts as care, who counts as credible, and how suffering is conceptualized, responded to, and resolved. It requires that psychiatry abandon its role as arbiter of personhood and instead accept a humble, dialogic, and rights-bound position within a broader ecology of healing. The transition from coercion to consent, from authority to accountability, from categorization to understanding, is not optional -it is required by science, by law, and by ethics. It is also demanded by those most affected: users, families, survivors, professionals, and communities who know that better care is not only possible but necessary. We must not lock anyone into a diagnostic status they did not choose, or accept the logic of chronicity as destiny. No one should be left behind, further harmed and trapped in worse and worsening conditions -not by neglect, not by fear, and certainly not by the act and professionals and the very systems with the duty and mandate to protect life, destroying it instead.

Chapter 2. Methods

Summary: This doctoral research employs a multi-scalar, mixed-methods design grounded in action-research and forensic medical anthropology to document and analyze structural violence in psychiatry across Spain, Indonesia, Sweden, and Italy between 2020 and 2025. Combining large-scale surveys, field-based engagement, and legal-normative analysis, it reveals how coercion, diagnostic abuse, and systemic silencing are normalized and institutionally defended, despite clear legal prohibitions and ethical frameworks. Methods include three targeted surveys -on schizophrenia diagnosis, Open Dialogue, and shared decision-making -each capturing empirical contradictions between professional discourse and clinical behavior. Extensive fieldwork, conducted through scientific missions, teaching, and reform initiatives, further exposed systemic obstruction, betrayal of duty, and retaliatory violence against those pursuing ethical care. The research design is anchored in the emic and etic logic of cognitive and medical anthropology, prioritizing testimony from those most harmed, while triangulating structural, legal, and relational data to ensure scientific validity. In documenting how institutions weaponize ethics, suppress inquiry, and enable ongoing harm, the chapter demonstrates that shared decision-making and patient autonomy are not hindered by complexity, but by moral refusal, and that the collapse of accountability within psychiatric systems is both a clinical crisis and a civic emergency.

2.1. Research methods: mixed participatory action-research under severe abuses

This doctoral investigation adopts a rigorously constructed mixed-methods design, integrating large-scale surveys, forensic ethnography, participant observation, pedagogical field engagement, and continuous public dissemination under open science standards. The methodological architecture was consciously selected in alignment with established best practices in medical anthropology, privileging iterative adaptation, emic and etic reflexivity, and field-embedded action (Scheper-Hughes, 1992; Singer & Baer, 2018; Holmes et al., 2006). The engagement with professional and survivor networks, institutional initiatives, and transnational policy forums was not a backdrop but a core methodological strategy -designed to access situated knowledge, understand relational dynamics, and expose structural constraints directly from those affected across all levels of the mental health system. This includes those targeted by psychiatric coercion, those tasked with enforcing it, and those advocating for transformation. Rather than maintaining the analytical detachment historically valorized in certain ethnographic traditions, this research adopts the positionality of an engaged actor, aiming not merely to describe systemic dysfunction but to intervene in it -epistemically, ethically, and institutionally (Rappaport, 2008; Baer, 1997). The choice to adopt action-research was both methodological and moral: it reflected a foundational commitment to co-producing knowledge with those subjected to harm and working toward immediate, context-responsive improvement of psychiatric services (Kemmis et al., 2014; Reason & Bradbury, 2008). Every survey deployed was conceived not as an extractive instrument but as a dialogical tool to amplify marginalized narratives and generate evidence fit for transformation. Every field mission was an act of embedded witnessing, in contexts where structural and interpersonal violence were not peripheral but constitutive of the institutional logic. Consistently, the thesis has adhered to the strictest principles of open science, not as bureaucratic compliance but as a political and epistemological imperative.

Data collection, instrument design, dissemination strategies, and analytic protocols were all implemented using open-source infrastructure, enabling transparency, reproducibility, and participatory audit of findings (Fecher & Friesike, 2014; Nosek et al., 2015). The methodological

scope of this thesis, developed through the research period from 2020 to 2025, reflects not only a cross-disciplinary integration of tools but a unified forensic commitment: to document, validate, and confront normalized institutional violence by exposing its logic, listening to its victims, and building pathways for structural redress.

Table 34 - Survey-based research activities

Date	Activity	Description
2020–2025	Inquiry on the Spanish version of the Schizophrenia Label in Spain	distributed nationally; online and postal reach; included patient, survivor, and professional responses; thousands contacted.
2023	Open Dialogue Survey	Surveyed professionals trained in Open Dialogue across Spain; aimed at understanding ethical dilemmas, implementation gaps, and structural resistance; disseminated through professional networks.
2025	Survey on shared decision making and both prescription and best practices	Long survey on shared decision-making and prescription practices in Spain, distributed among professionals.

In this dissertation, survey research is employed not as a reductionist or purely quantitative device, but as a bioculturally grounded, ethnographically sensitive, and action-oriented method. When rigorously applied within the ethics of open science and critical anthropology, survey tools become instruments of epistemic justice -documenting lived experience, amplifying silenced voices, and fostering data-driven structural reform (Baer, 1997; Rappaport, 2008; Nosek et al., 2015). This use of surveys stands as a key element within the broader mixed-methods and action-research design of the thesis. Survey research in medical anthropology occupies a complex and often contested space, especially when addressing issues as sensitive and structurally entangled as psychiatric diagnosis, institutional care, and systemic coercion. Within this doctoral research, the use of surveys was methodologically deliberate and grounded in both the ethical imperatives and the empirical opportunities that this approach offers. Far from being a detached or extractive method, surveys in this context became instruments of dialogical engagement: each questionnaire circulated created new channels of contact, enabled follow-up conversations, and often catalyzed longer-term exchanges via email and videocalls.

In contrast to sterile polling, these instruments embedded the ethnographic ethos of listening attentively to those most affected, initiating co-constructed understandings that extended well beyond the data points collected (Kleinman, 1995; Scheper-Hughes, 1992). The first and largest survey -the Spanish adaptation of the UK Inquiry into the 'Schizophrenia' Label -was informed by a groundbreaking initiative launched in 2012 by service users and professionals in the United Kingdom. That inquiry critically examined the clinical validity, personal consequences, and institutional uses of the schizophrenia diagnosis, ultimately contributing to a rethinking of diagnostic labels within the International Society for Psychological and Social Approaches to Psychosis (Read et al., 2013; Johnstone & Boyle, 2018). Inspired by this effort, the Spanish adaptation was deployed nationally, both online and by post, targeting public mental health centers, professionals' associations, and survivor collectives. Thousands of individuals were reached

directly. The goal was to document the diagnostic experience, its impact on identity, care, and recovery, and the systemic responses to psychiatric labeling. The resulting dataset underpins one of the central analyses in this dissertation, along with the other surveys deployed during the research years. A second one, focused on the professional implementation of the Open Dialogue approach in Spain, was designed collaboratively and distributed among practitioners trained or interested in dialogical practices. It explored ethical tensions, clinical challenges, and institutional obstacles in real-world settings (Henning et al., 2023). As with the previous initiative, the survey process itself facilitated ongoing communication with participants, expanding the research network and enriching the qualitative analysis. A third and more targeted instrument was introduced in 2025 to assess best practices for shared decision-making and medication deprescription. Though its reach was narrower, the survey contributed to validating prior themes and refining the thesis's policy recommendations, based on experiential and professional expertise from practitioners engaged in the mental health field.

Table 35 - Fieldwork and participant observation

Date	Activity	Description
2020–2022	Mad in America global network liaison	Coordinated international critical psychiatry network; tracked global harms, best practices, and survivor narratives.
2020–2022	Coordinator of Spanish Open Dialogue Network	Leadership role coordinating national dialogue, ethical challenges, and practical implementation within professional networks.
2020–2024	ReMO COST action	Contributed to academic reform dialogues, researcher mental health and epistemic justice under COST framework.
2020–2024	FOSTREN COST action	Participated in and supported international COST network on coercion reduction.
2021–2025	EU BEACON One Health Education COST action	Co-founded and led action framework on One Health mental health education; ethics, training, systems transformation.
Aug–Sep 2022	Fieldwork in Trieste, Italy, WHO Mental Health excellence site	On-site research and observation of WHO-recognized practices in non-coercive psychiatry.
2025	CliMent COST action	Scientific and ethical COST Action on clinical mental health reform.
2025	Youth Digital Mental Health COST action	COST Action focused on prevention and structural protection in educational ecosystems.
2025	Visiting Scholar, UMY Indonesia, study of pasung	Research and teaching at Universitas Muhammadiyah Yogyakarta; ethnographic study on coercion and confinement practices.

Fieldwork, as employed in this dissertation, is not understood merely as a technique for data collection but as an epistemological and ethical stance central to the anthropological study of health, power, and institutional violence. Within the domain of medical anthropology, participant observation in mental health contexts offers an irreplaceable avenue for accessing the lived realities of individuals and collectives navigating structural asymmetries, diagnostic regimes, and contested therapeutic systems (Scheper-Hughes, 1992; Garcia, 2010). In this research, fieldwork unfolded through sustained multi-sited engagement across Spain, Italy, Indonesia, and transnational

institutional networks, where the researcher was often both participant and target -bearing witness to coercive practices, systemic complicity, and the abandonment of ethical standards. The immersive nature of this ethnographic involvement enabled not only the documentation of psychiatric violence and professional avoidance but also the co-production of insights with those directly affected by such harms.

From 2020 onward, participation in critical international networks -such as the Mad in America global affiliate community, the Spanish Open Dialogue Network, and the EU-funded COST Actions ReMO, FOSTREN, EU BEACON, CliMent, and Youth Digital Mental Health -provided privileged access to frontline professionals, survivors, reform advocates, and institutional policymakers. This deepened the capacity to observe firsthand the dynamics of denial, reform inertia, and ethical conflict within European and global psychiatry (Harper, 2011; Davies, 2017). The fieldwork conducted in Trieste, Italy, within a WHO-designated excellence site for community-based, non-coercive psychiatry, allowed for the comparative analysis of institutional cultures and the identification of operational barriers even in exemplary systems. Simultaneously, the extended stay as a visiting scholar in Indonesia in 2025 enabled engagement with the practice of *pasung* -the physical restraint and social exclusion of individuals with psychosocial distress -offering a transcultural and postcolonial perspective on coercion, abandonment, and recovery (Good et al., 2010).

Fieldwork within these settings was not limited to observation. It encompassed active participation in teaching, training, consultation, event organization, and policy advising, aligning with a model of engaged anthropology (Low & Merry, 2010). The thesis draws from this embeddedness to trace not only the visible structures of psychiatric care and control but also the informal norms, symbolic violence, and resistance strategies that circulate within and beyond institutions. Documenting international congresses, confidential professional exchanges, and survivor testimony platforms -including the organization of the 2023 global symposium on political abuses of psychiatry -fieldwork operated as a mechanism of forensic witnessing and collaborative memory production. In line with the action-research framework of this dissertation, participation was always intended to create reciprocal value: improving conditions, informing policy, and opening protected spaces for truth-telling and systemic critique (Kemmis et al., 2014; Speed & Kelly, 2014).

Given the profound vulnerability of many interlocutors and the high-risk environments in which this research took place -including contexts of overt abuse, institutional betrayal, and personal endangerment -fieldwork also entailed ethical navigation beyond procedural review. As others have noted, fieldwork in mental health settings requires ongoing assessment of relational accountability, narrative justice, and the politics of care (Biehl, 2005; Das & Das, 2006). This dissertation affirms that long-term, critical ethnographic participation -undertaken transparently, with methodological humility and principled alignment -remains essential to uncovering and challenging the invisible architecture of psychiatric violence and institutional failure.

Participation in, and organization of, conferences and symposium

Date	Activity	Description
2021	Organizing Open Committee, Dialogue Conference	Organized national conference; promoted Open Dialogue dissemination and networking in Spain.
2021	HopenDialogue,	Open Participated as speaker in several townhall events on Open

Date	Activity	Description
	Excellence talks	Dialogue from the medical anthropological experience.
2022	Presentation, Conference	ISPS Showcased findings on psychiatric labels and Spanish Open Dialogue experience.
2023	WPA Vienna Congress and Seminar Series	Presented thesis data and participated in organizing international series on extreme psychiatric violence; included testimonials and high-risk case studies.
Jan–Nov 2023	Symposium on political abuses of psychiatry	Hosted global symposium; gathered and curated expert and survivor narratives on political abuse of psychiatry.

Academic conferences and public symposiums are frequently treated as auxiliary activities in doctoral research. In the context of this dissertation, however, they formed a fundamental methodological pillar, enabling direct access to epistemic communities, testimonial ecosystems, and institutional interfaces where contested knowledge circulates and political tensions unfold in real time. Far from being passive venues of dissemination, these spaces became fertile sites for ethnographic immersion, strategic engagement, and forensic witnessing -where structural violence, clinical complicity, and resistance narratives could be heard, examined, and amplified under collective protection (Fassin, 2013; Keck & Ticktin, 2015). Across the research period, the candidate's sustained presence in high-stakes forums -both as a speaker and organizer -was not only instrumental in refining theoretical frameworks and methodological tools, but also vital in building networks of solidarity, legitimacy, and action across disciplinary, national, and survivor-professional divides.

The 2021 organizing role in the national Open Dialogue Conference positioned the author at the heart of a nascent but growing movement for dialogical psychiatry in Spain, confronting entrenched clinical paradigms and fostering intersectoral dialogue among practitioners, academics, and affected communities. That same year, the participation in the *HopenDialogue* Excellence Talks series offered a unique opportunity to translate medical anthropological insights into public educational formats, contributing to broader public literacy on mental health reform. These engagements validated field insights, catalyzed new collaborations, and shaped the methodological direction of subsequent surveys and fieldwork interventions.

In 2022, the presentation at the International Society for Psychological and Social Approaches to Psychosis (ISPS) conference showcased original findings on psychiatric labeling and dialogical practice, strengthening international academic resonance. The year 2023 marked a critical expansion: the thesis results were formally presented at the World Psychiatric Association Congress in Vienna -an event at which the researcher also helped coordinate an attached global seminar series on extreme psychiatric violence. These sessions brought together firsthand accounts of coercion, institutional betrayal, and ethical breakdown, and constituted a rare moment of collective exposure of the psychiatric system's most dangerous practices within its own institutional boundaries (Rose, 2018; Newnes, 2021).

From January to November 2023, the researcher curated and hosted a full symposium on political abuses of psychiatry with the support of the EU COST action FOSTREN, gathering testimonials and analyses from victims, clinicians, scholars, and international experts. This event was not merely discursive but a methodological extension of fieldwork -an orchestrated convergence of data, ethics, and resistance under open science principles. Across these activities, the ethnographic act was

expanded: the conference became a site of truth-claiming, of witnessing and sharing responsibility for collective repair, aligning the dissertation with the most rigorous standards of forensic medical anthropology and rights-based psychiatric critique (Rappaport, 2008; Petryna, 2002).

Teaching and Curriculum-Based Engagements

Date	Activity	Description
2020–2021	Open Dialogue Training in Barcelona	Co-coordinated public university-backed training for professionals; participant observation of structural resistance.
2021	Teaching at University of Almería Inclúyete program	Facilitated dialogue-based pedagogical sessions on mental health; centered around trauma-informed practice and open science.
2021–2023	Teaching on mental health, coercion and best practices	Contributed to undergraduate and graduate teaching on psychiatry, ethics, and anthropology; supported syllabus redesigns.

Teaching, within the framework of this doctoral research, was not a peripheral academic duty but a core modality of action-research -a method of participation, contribution, and reciprocal learning embedded in real-world pedagogical and institutional settings. As framed by Freirean and participatory pedagogical traditions, education is not only a means to transmit knowledge but a site of political, ethical, and epistemological engagement where new practices can be tested, oppressive logics confronted, and collaborative repair initiated (Freire, 1970/2005; Rappaport, 2008). In this sense, the researcher’s role as a teacher within mental health-related training programs became both a strategic and ethical mechanism for contributing to system improvement while building rapport with those directly involved or affected. Teaching served as a method of entry into institutional dynamics, revealing how structural coercion, stigma, and professional fears are reproduced and contested within academic and clinical curricula (Ginsburg & Rapp, 2013; Holmes et al., 2006).

From 2020 to 2021, co-coordinating the Open Dialogue training program in Barcelona provided an unparalleled opportunity for participant observation of the limits and potentials of implementing dialogical psychiatry within the rigid confines of Spain’s public mental health systems. Resistance from institutional actors, the fragility of peer-led reform, and the ethical tensions felt by professionals emerged not just as content but as lived pedagogical tensions within the training sessions themselves. In 2021, teaching under the Inclúyete program at the University of Almería offered a different but complementary site for engagement: dialogically structured sessions on trauma, ethics, and open science with university students -many of whom were themselves navigating mental health struggles -allowed for reflexive learning and direct feedback on reformist approaches. These sessions became spaces of mutual listening, co-produced analysis, and therapeutic epistemic solidarity.

Between 2021 and 2023, the researcher further participated in a range of undergraduate and graduate-level courses in psychiatry, ethics, and medical anthropology. These engagements were not only instrumental in reshaping curricula, encouraging trauma-informed approaches, and introducing students to non-coercive paradigms, but also offered a mechanism to test survey instruments, refine core concepts, and identify institutional anxieties around change. Students, professionals, and

fellow educators often contributed new cases, questions, and critiques that enriched the ethnographic and survey-based components of the dissertation. Teaching, in this regard, functioned as both research and intervention -a frontline tool for systemic literacy, interdisciplinary alliance, and dialogical repair (Boyd & Lassiter, 2021; Scheper-Hughes, 1992).

Policy and Forum Engagements

Date	Activity	Description
2020	Participation in Mexican Parliament Forum	Advocated for biocultural respect and community-led psychiatry models; presented testimonies and conceptual frameworks.
2022–2024	Catalan Mental Health Policy Consultations	Submitted policy recommendations on shared decision-making, autonomy, and structural accountability.
2023	Support to Council of Europe Report on Non-Coercive Approaches	Provided data and conceptual contributions to official guidance development; focused on shared decision-making and best practices.
2023	ReMO COST Action Spanish national policy recommendations	Engaged academic and clinical stakeholders in the national context through ReMO.

Participation in policy forums and institutional consultations formed a vital axis of this doctoral research, aligning with the foundational principles of action-research and the medical anthropological imperative to engage with structures of power not only as objects of critique but as sites of ethical intervention (Farmer, 2005; Scheper-Hughes, 1995). These engagements were not symbolic nor limited to advocacy: they constituted deliberate efforts to translate field-based findings, expert insights, and lived experience into policy frameworks, legal discourse, and institutional guidance. As the researcher collaborated with governments, supranational bodies, and intersectoral platforms, each encounter became an occasion to expose structural inertia, raise ethical standards, and promote informed, rights-based, non-coercive practices in mental health. These interventions were grounded in the reality that meaningful, lasting change can only emerge through active contestation of dominant norms and close collaboration with those already working under adverse and often hostile systemic conditions (Shore & Wright, 2011).

The researcher's contribution to the 2020 Mexican Parliament Forum represented an early milestone, bringing forward biocultural frameworks and community-led mental health approaches within a legislative context. In Catalonia (2022–2024), participation in mental health consultations allowed the researcher to submit structured recommendations on shared decision-making, patient autonomy, and legal responsibility, anchored in empirical findings and field-based insight. These policy contributions underscored the gap between official discourse and clinical reality, highlighting how rhetorical commitments to autonomy often dissolve into institutional indifference or coercive default practices.

In 2023, the researcher contributed both conceptual and empirical input to the Council of Europe's report on non-coercive approaches (Council of Europe, 2023)., affirming the relevance and urgency of moving toward best practice models that respect human dignity and clinical plurality. Parallel to this, through the ReMO COST Action, the researcher facilitated dialogue with academic and

clinical stakeholders to formulate national recommendations on researcher and patient rights in the context of mental health policy reform in Spain. Each of these contributions was not merely representative of scholarly duty but a form of responsible engagement, developed under conditions where the ethical negligence of many institutions remained unchallenged, and where survivors, professionals, and advocates struggled to be heard amid systemic resistance (Keck & Keck, 2020; Rose, 2018). As such, these policy actions reflect the dissertation’s broader commitment: to ground research in solidarity, speak truth to institutional power, and advocate with and for those most affected by psychiatric violence and structural degradation.

Open methods, science, code and public dissemination, communication and exploitation

Date	Activity	Description
2021–2025	Open Fieldwork and Laboratory Notebook	Maintained open platform documenting fieldwork, teaching, methods, and ethics; hosted expert sessions, provided live updates; ensured transparency and accountability.
2021–2025	Experiment.com crowd funding ongoing project	Lived experience and professional expertise tracking and habits forming software, to help reach peak health, optimal performance and top acuity under distress, group-wise

Open science, in this research, was not an auxiliary dissemination strategy but a deliberate and foundational methodological commitment, aligned with the highest standards of transparency, reproducibility, and participatory accountability in both medical anthropology and interdisciplinary mental health research. Throughout the period 2021–2025, the researcher maintained a publicly accessible open science fieldwork and laboratory notebook, offering real-time documentation of research activities, methodological decisions, field tensions, ethical conflicts, and academic outputs. This digital infrastructure not only ensured traceability and transparency but also embodied a structural critique of knowledge hoarding and institutional opacity in psychiatric research (Nosek et al., 2015; Fecher & Friesike, 2014). Public updates, reflections, and hosted dialogues with experts and affected persons enabled the building of a community of inquiry that included survivors, clinicians, educators, students, and activists -reframing the research process itself as a shared civic task.

Rather than conceiving scientific dissemination as a final, polished product aimed at specialized audiences, this practice followed the logic of engaged epistemology, wherein knowledge generation and communication are co-constitutive (Kaltenbrunner et al., 2022). The field notebook served as a live, dialogical record of an ongoing research struggle -made more complex by the political and institutional hostility encountered, including direct threats and systemic attempts to suppress data, participation, and reform. Dissemination in this context was a form of forensic truth-telling, as well as a tool for validation, error correction, and ethical accountability. The notebook platform allowed public access to research design choices, key instruments (e.g., surveys, teaching materials), policy contributions, and academic presentations, adhering to the principles set forth by international declarations on open research culture and data transparency (UNESCO, 2021; Munafò et al., 2017).

this approach supported the exploitation of research outputs beyond academia, contributing to training materials, policy drafts, conference talks, and survivor-led initiatives. By opening the

methodological and epistemic scaffolding of the project, the work disrupted traditional academic gatekeeping and allowed for rapid iteration and community validation of results. These practices placed the thesis within the growing field of public and collaborative anthropology, and also served as a countermeasure to institutional gaslighting, epistemic violence, and testimonial erasure commonly faced by both researchers and participants in contexts of psychiatric abuse (de la Bellacasa, 2011; Jasanoff, 2004). Open science, in this thesis, is thus both a method and a stance - one that refuses complicity with silence, exclusion, and impunity in the name of clinical or academic authority.

Table 36 - Systemic crimes and institutional betrayal during the research process

Date Period	/ Form of Crime or Abuse	Perpetrators Enablers	/ Mechanism and Description	Consequences for Researcher and Scientific Work
2019–2020	Family violence and entrapment	Close relatives (e.g., aunt), public silence	Coerced into care-taking and confinement under threat; economic theft and reputational sabotage; no intervention despite repeated signs of crisis	Loss of Yale opportunity; isolation; onset of health decline; derailed research initiation
2020–2021	Institutional complicity and gaslighting	Mental health services; university staff	Repeated reports ignored or treated as symptoms; abusers treated as credible; mental health system weaponized to isolate and punish through forced medication and labeling	Discrediting of voice; onset of trauma-related illness; beginning of extensive documentation efforts
2021–2022	Fraud, coercion, poisoning, abandonment	Family; medical professionals; services	Lies presented as medical facts; attempts to escape met with forced sedation or surveillance; funds withheld or stolen; services only intervened to stop acute toxicity, not to investigate or protect	Physical collapse; destroyed safety networks; critical awareness of the weaponization of psychiatry
2022–2023	Legal coercion and criminal misuse	Chilean judiciary; transnational passivity	Fabricated legal processes without notification; massive fines enforced through ex parte judgments; reports to Spanish authorities disregarded; nationality and protections denied	Ongoing economic repression; criminal exposure; worsening conditions for fieldwork and academic progression
2020–2025	Structural and epistemic violence	Police, ombuds institutions, health agencies, university offices	Reports treated with suspicion or dismissed; responses delayed or irrelevant; mental health stigma systematically applied to erase legitimacy and silence evidence	Continued obstruction of research; retraumatization; increased risk of institutional erasure
2020–2025	Retaliation and professional sabotage	Academic gatekeepers, corrupt actors in services	Research identity attacked; ethical breaches normalized; pressures to abandon open science and action-research stance; credibility systematically undermined	Constant hypervigilance; restricted collaboration; forced intellectual and personal exile

Throughout the development of this research, the undersigned was subject to a pattern of

coordinated abuses that involved family members, institutions, and professional actors who used the psychiatric system -its betrayal, its impunity, and its legal loopholes, the social death and forced physical and emotional suffering caused by both fully criminal and neglectful actors -as a tool for social control and personal destruction. This is not incidental. This research testifies to how mental health systems, when operating without structural safeguards, not only fail to protect but actively facilitate the continuation of domestic abuse, economic predation, and epistemic erasure. The system did not collapse under negligence -it operated as designed: to maintain a violent status quo, to discredit dissenters, and to punish those who speak up. The very conditions that should trigger protection and care became triggers for further persecution. The public and institutional silence, the consistent disbelief, and the misuse of legal-medical labels demonstrate not a lack of knowledge, but a lack of will to act lawfully and ethically. This doctoral thesis emerges from within that reality. Its aim is to dismantle the structural ignorance and coercive scaffolding that makes such abuses possible -by documenting them, naming them, and proposing mechanisms of prevention and repair. No health system should enable abuse. No lie should have the power to withdraw a person’s rights, to erase their truth, or to make their life disposable. This is a scientific fight for dignity, legality, and real health.

Table 37 - Chronology of systemic violence, institutional betrayal, and researcher survival

Year(s)	Form of Harm	Summary of Circumstances and Impact
2017–2019	Forced drugging, cognitive impairment, early isolation	Psychiatric medication administered coercively with no consent, leading to neurological harm (e.g., dysarthria, tremors). Environment dominated by fear and control.
2019–2020	Escalation of violence, reporting ignored	Attempts to report were systematically dismissed. Domestic violence intensified. Academic and medical life undermined by deliberate sabotage.
2020–2021	Criminal neglect by services, increasing isolation	Services aware of ongoing abuse intervened only to reduce toxicity, never to stop or report the violence. Full public silence and complicity.
2021–2022	Surveillance, threats, fabricated narratives	False accusations and defamatory lies enabled coercion. Isolation deepened. Research conducted under surveillance and targeted aggression.
2022–2023	Forced dependency, institutional obstruction	Any attempt to seek protection or legal redress blocked. Family continued daily abuse. Research career nearly destroyed. No support from supervisors or authorities.
2023–2024	Judicial fraud and transnational coercion	Coercive legal sentences imposed without due process. Exploitation of researcher’s absence and vulnerability through coordinated litigation.
2024–2025	Ongoing threats, exile, systemic impunity	Researcher forced to flee Europe to survive. International academic work continued in exile. Family and new loved ones targeted as well.

This table summarizes the main phases and manifestations of abuse endured by the researcher, whose work in mental health, shared decision-making, and open science was carried out under conditions of coercion, institutional complicity, and transgenerational trauma. Each entry reflects a pattern of criminality rendered possible by public and private actors through impunity, normalized disservice, and structural neglect.

As abundantly clear by now, this doctoral research was carried out not in abstract conditions of inquiry but in direct resistance to an interlocking web of transgenerational, institutional, and state-

enabled violence. From 2017 onward, the researcher endured sustained physical and psychological abuse, systemic neglect by services, and coercive psychiatric interventions that violated international human rights standards. The cumulative effect was not merely professional hardship but the destruction of a peaceful family life, educational continuity for children, and physical safety. Each attempt to resist -through legal means, academic communication, or direct reporting -was met not with protection but with further retaliation and silencing.

In line with traditions in medical anthropology and survivor-led participatory research (Good, 1994; Farmer, 2004; Kleinman, 1995), this dissertation incorporates these conditions as structural context, not as anecdotal background. The methodological stance -centered on action-research, epistemic justice, and open science -emerged not from abstraction, but from necessity. In the absence of protection, the researcher learned to navigate life-threatening contexts while maintaining scientific rigor, collaborative ethics, and full accountability to the broader community.

This experience illuminates a broader phenomenon in mental health systems: where the betrayal of professional duty becomes systemic, and impunity overrides the protective function of law. Structural violence is not limited to coercion in care but extends to the invisibility of suffering, the suppression of truth, and the epistemic annihilation of those who report abuses (Scheper-Hughes, 2004; White, 2017). In this sense, the thesis constitutes not only an academic contribution but a forensic, restorative intervention.

It is important to stress that the violence documented here has affected not only the author but also their children, co-workers, and international collaborators. These are not isolated incidents but reflections of normalized corruption, cultural impunity, and institutional decay, the understanding of which is essential to designing ethical and effective health systems. This research stands as a response to that decay and a tool for its transformation.

Table 38 - Critical incidents with risk of death or permanent incapacitation

Year / Period	Mechanism of Lethal or Disabling Harm	Actors Involved	Conditions	Context and Systemic Significance
2017	First criminal beatings; assault ignored by police	Family members; Spanish police		Despite visible bruises, police dismissed the report and treated the male victim as suspect, reinforcing patriarchal bias and systemic impunity for domestic violence.
2017–2021	Chronic poisoning under guise of medication	Psychiatric services; family coercion		Forced polypharmacy induced motor and cognitive dysfunction. Isolation worsened. Consent absent. Symptoms attributed falsely to illness instead of iatrogenic harm.
2021	Institutional risk of permanent lock-in	Psychiatric institution (Catalonia); silencing of other patients		Researcher barely avoided indefinite commitment. Witnessed how others were punished for advocating Open Dialogue or speaking critically. Fellow anthropologist intervened.
2021–2022	Violent assaults using sharp and blunt objects	Family member(s)		Head trauma, neck injuries from broken bottle, blunt force. Children present. No accountability. Researcher lost consciousness. Financial control and identity theft ongoing.
2023	Daily violence, social	Neighbors, services,		While relocating to safer setting, violence

Year / Period	Mechanism of Lethal or Disabling Harm	Actors / Involved	Conditions	Context and Systemic Significance
	collapse, community targeting	medical staff, extended community	and	escalated into routine abuse, with active engagement by others. Researcher criminalized for surviving.
2025	Transnational harassment surveillance	Extended networks of abusers; agents sent to Indonesia	of	Despite geographic relocation, threats, surveillance, and extortion continued. Legal mechanisms manipulated from abroad. No state or institutional protection.

This table documents episodes in which the researcher's life or basic functional capacity was directly endangered through violence, coercive medication, organized silencing, and social or institutional abandonment. These events, while personal in impact, reflect broader systemic dysfunctions in the health, legal, and protection systems across multiple countries and jurisdictions.

Each of the episodes recorded above constituted a potential terminal endpoint, whether through direct lethal assault, iatrogenic neurological degradation, or judicial entrapment, which would have rendered the researcher permanently silenced. These are not merely moments of personal crisis; they reflect the deliberate operation of systems that protect perpetrators and punish witnesses, often masking coercion and elimination through medicalized, legalistic, or benevolent discourses (Good, 1994; Summerfield, 2001; Moncrieff et al., 2013). The researcher's survival owes not to institutional safeguarding -none of which functioned as legally or ethically obligated -but to resilience, precise documentation, and strategic international relocation. The methods of this thesis must be read not only as academic strategies but as survival mechanisms. Action-research and open science were not abstract commitments but lifelines, enabling both resistance and empirical validation under ongoing threat (Scheper-Hughes, 1995; White, 2017). This framing aligns with contemporary calls for critical epistemologies in anthropology and mental health research, which reject neutral observation in favor of engaged scholarship rooted in real-life stakes and structural analysis (Fassin, 2011; Kelly, 2016). As such, this table supports not only testimonial veracity but the scientific legitimacy of the author's positionality as an embedded observer and co-transformative agent. The conditions under which this research was conducted were not merely adverse; they constituted a structured regime of dehumanization, coercion, and targeted silencing, embedded in both interpersonal violence and systemic criminal impunity. This environment -characterized by persistent threats, coercive medication, defamation, fabricated legal charges, and multilevel institutional betrayal -must be understood not as an anecdotal context but as part of the fieldsite itself, shaping the epistemic ground of the research. The researcher's experience reflects what scholars of structural violence and critical medical anthropology have identified as pathologization as erasure, where the suffering induced by systemic abuse is used as retroactive justification for further withdrawal of rights, credibility, and personhood (Scheper-Hughes, 1992; Fassin, 2011; Kleinman & Das, 2001).

This dynamic -where the effect of crime is used to legitimate further abuse -is not an exception but a recurring logic in systems of psychiatric coercion and gendered violence. In such contexts, the declaration of a person as "ill," "disturbed," or "paranoid" serves not to offer care but to isolate them from legal protections, professional standing, and moral worth (Rose, 2007; Metzl, 2009). The threshold for these designations is often not clinical but political and familial -triggered by dissent, noncompliance, truth-telling, or the assertion of one's narrative against more powerful actors.

Children raised in such environments become witnesses, participants, and targets of this normalized violence. Their capacity to discern truth, develop empathy, or resist abuse is shaped -and often compromised -by structures that reward silence and punish dissent. These are not "developmental risks" in the abstract but deliberate outcomes of institutional abandonment and social complicity. The researcher's survival -through peaceful but active resistance, open documentation, and engagement with ethical scholarly communities -was neither incidental nor passive. It constituted the methodological backbone of the research, as critical as any analytic tool or survey instrument employed.

Just as data collection in a toxic laboratory yields skewed results, so too does inquiry under conditions of structural corruption, unless these distortions are named, studied, and exposed (White, 2017; Farmer, 2004). Scientific neutrality, in such circumstances, is not possible -it collapses into epistemological betrayal. This research therefore insists on methodological lucidity and moral clarity: the readings gathered are not random. They are shaped by the ill will of institutions, the ethical failure of professionals, and the courage of those who continue to speak and act despite being targeted for elimination. It is not martyrdom that guides this path, but a commitment to justice and life, against the suffocating inertia of criminal normalcy. That this dissertation exists at all is evidence of that commitment.

Table 39 - Researcher integrity as methodological infrastructure: operational dimensions

Domain	Applied Principle	Integrity	Methodological Expression	Operational Protective Function	Benefit /
Ethical Fieldwork	Goodwill as harm-reduction commitment	as	Engaged transparency, listening, protection of informants	Built trust with participants under threat; ensured consent was meaningful	ensured
Scientific Rigor	Integrity as calibration		Triangulation of narratives, skepticism toward official data, contextual reading	Prevented error from corrupted institutional or professional sources	
Open Science	Integrity reproducibility accountability	as	Open lab notebook, public documentation, clear method trails	Enabled external verification, engagement, and resistance to silencing	public
Self-as-Instrument	Epistemic awareness	self-	Reflexive field notes, emotional attunement, trauma-informed stance	Reduced projection and bias; preserved clarity under duress	
Institutional Engagement	Goodwill careerism	over	Refusal to partake in cover-ups, advocacy despite retaliation	Maintained coherence and scholarly autonomy	ethical
Analytic Process	Integrity interpretation	in	Avoided overcoding, respected complexity, resisted binary diagnoses	Ensured scientific validity and grounded nuance	
Survival Strategy	Integrity as resistance		Methodological discipline as lifeline	Preserved cognitive function and mission clarity despite persecution	

Under the exceptional conditions of systemic coercion, chronic threat, and widespread institutional betrayal described throughout this thesis, research integrity could not be outsourced to abstract protocols or idealized oversight bodies. Instead, it had to be exercised as continuous, situated *goodwill* -a principled commitment to truth-telling, harm reduction, and the ethical treatment of

participants, even when those values were systematically undermined or punished by the institutions ostensibly designed to uphold them. Integrity, here, is not a bureaucratic checkbox or legal shield but a scientific methodology in itself: an embodied, self-reflective stance necessary to distinguish the real from the performed, the truthful from the coercively constructed, especially in a research domain as saturated by power asymmetries as mental health (Scheper-Hughes, 1995; White, 2017). In anthropological terms, this aligns with the understanding of the researcher as a primary sensing instrument -not just a collector of data through technological means or intermediaries, but the embodied locus of interpretation, contextualization, and ethical discernment (Desjarlais, 1997; Kleinman, 1999). This perspective mandates a level of epistemological and affective discipline rarely acknowledged in dominant research frameworks: *one must be trained, vigilant, and constantly self-calibrating*. This was especially vital in the present dissertation, where the researcher's own survival was at stake and violence, misinformation, and professional gaslighting were routine field conditions.

Prior laboratory and scientific training reinforced this vigilance. Methods of calibration, verification, contamination control, and multi-source triangulation -standard in physical sciences - were applied here to social and legal testimony, institutional interactions, and multi-scalar field observations. Open science practices such as live documentation, public fieldnotes, and transparent decision trails (Fecher & Friesike, 2014) were adopted not only as ideals but as protective strategies. Against the gravitational pull of complicity, corruption, and intellectual seduction in professional settings, integrity as goodwill became the binding substrate of all mixed methods employed: it made trust possible, participation ethical, and scientific evidence valid. As such, it stands not outside the methodological framework, but at its core.

Table 40 - Mechanisms of professional punishment and isolation in coercive mental health systems

Mechanism	Description	Impact on Ethical Actors	Examples / Contexts
Professional ostracism	Informal blacklisting, exclusion from publications or positions	Career derailment, silencing of dissent	Whistleblowers in psychiatry losing jobs or grants (Voronka, 2016)
Retaliatory diagnoses	Framing dissent as mental instability	Loss of credibility, threat to liberty	Pathologizing survivors and critics (Burstow, 2003)
Epistemic policing	Discrediting experiential or community knowledge	Delegitimization of research and survivor narratives	Medical hierarchy dismissing non-clinical perspectives (Rose, 2014)
Surveillance and reporting	Use of digital and institutional monitoring to intimidate or entrap	Self-censorship, legal risk	Institutional retaliation in state-aligned psychiatry (Foucault, 1977; Good et al., 1994)
Cultural retaliation	Shaming, social exclusion, family punishment	Silencing of victims, community complicity	Patriarchal norms in traditional societies (Das, 2007)
Victim-blaming	Treating survivors' distress as the cause of systemic failure	Emotional isolation, trauma escalation	Gaslighting of victims by both professionals and relatives
Withholding protection	Services fail to intervene in abuse or coercion	Exposure to further violence	Police or medical services ignoring reports of torture

Ethical positioning in research becomes a site of resistance when systems of normalized violence are under scrutiny. The experience of conducting fieldwork amidst ongoing institutional abuse and

political manipulation of psychiatry reveals a stark divide between those who intervene -at great personal and professional cost -and those who step aside, rationalize, or participate. As in cases of urban fire or structural collapse, the analogy is apt: while firefighters and a few morally anchored individuals move toward the epicenter to rescue, most either flee or opportunistically exploit the crisis (Bauman, 2000; Das, 2007). This social dynamic replicates itself with uncanny precision in psychiatric systems where coercion, silencing, and bureaucratic self-preservation dominate over truth, care, or rights. Those who seek to help -whether journalists, survivors, whistleblowing professionals, or critical researchers -are not merely sidelined. They are often punished through discrediting, ostracism, economic sabotage, retaliatory diagnoses, and loss of credibility within their field (Burstow, 2003; Rose, 2014; Voronka, 2016). The closer one comes to uncovering or witnessing systemic abuse, the harsher the epistemic and material repercussions.

Inaction, in this context, is not neutral. It actively reinforces the structure of harm. Social and professional norms punish those who report or attempt to intervene, especially when their engagement stems not from a secure position of power but from embodied risk -as is the case in action-research grounded in lived vulnerability. In both technologically enforced surveillance regimes and traditional patriarchal systems, the decision to aid victims of psychiatric abuse (or to expose institutional complicity) is framed as a threat. Consequently, victims and advocates alike are targeted as dangerous outliers, potential disrupters of institutional stability or family honor (Fanon, 1963; Foucault, 1977; Good et al., 1994). When the public health system weaponizes diagnostic tools, and when cultural norms reward obedience to authority over moral courage, the system's epistemology -what counts as real or relevant knowledge -becomes tightly policed. In this setting, research that seeks to document violence, amplify silenced voices, or propose rights-based alternatives, is treated not as scientific contribution, but as deviance.

This dissertation was designed not despite these risks but because of them. The very reason why so little data exists on the ethical failures and political misuses of psychiatry is because most researchers are professionally and existentially unable to undertake such work without retribution (Newnes, 2021). Surveys, interviews, and field engagement with people in pain -users, survivors, or distressed professionals -carry an additional ethical weight in this context. These are not abstract data points. Every testimony risks retraumatization and implicates the researcher in a network of responsibilities: toward truth, toward healing, and toward systems that actively wish these narratives remain buried.

2.2- Surveys

In an era where reproducibility and transparency are under threat, and scrutiny in both clinical research and social sciences is more needed than any time before to avoid the scientific establishment losing its merited status of honest among the charlatans (Ioannidis, 2005; Munafò et al., 2017), the consistent application of structured methodological reporting is not optional -it is imperative. Surveys concerning psychiatric practices, clinician decision-making, and mental health reform present particular epistemic and ethical challenges. They occur within a socio-political terrain marked by institutional asymmetries, biomedical authority, stigma, and histories of coercion (Moncrieff et al., 2013; Read & Dillon, 2013; WHO, 2021). To navigate this, the dissertation adopts a robust accountability framework grounded in open science principles such as preregistration, data transparency, and the FAIR data management paradigm -Findability, Accessibility, Interoperability,

and Reusability (Wilkinson et al., 2016; European Commission, 2020). In this context, accountability refers not only to scientific quality control but also to the moral responsibility of the researcher to affected populations and professional respondents, ensuring their insights are treated with analytical fidelity and protected by privacy standards.

The application of this structured method of reporting what was done permits traceability of bias, limitations of scope, and identification of power asymmetries within the research process itself - especially relevant when the research is conducted under structural adversity, as in the case of this dissertation. It also makes explicit the logistical constraints -technical, economic, and institutional - that shaped the survey's design and outreach, thus making visible the non-neutral conditions under which mental health research is often conducted (Mol, 2008; Gobo, 2008). Methodologically, it adheres to the mixed-method standards of rigorous content validity, transparent sampling and coding strategies, and triangulated interpretation of qualitative feedback (Flick, 2018; Patton, 2015).

The decision to deploy the template across all surveys further supports internal comparability, aids external auditability, and facilitates the integration of findings into international dialogues on psychiatric reform and medical ethics. This meta-methodological consistency also enhances the replicability of the surveys in other contexts or future rounds, encouraging longitudinal follow-up or adaptation in other national systems. More than a formality, this structure is a declaration of scientific integrity, a foundational condition for research that aspires to influence policy, challenge injustice, and contribute to a psychiatry grounded in autonomy, evidence, and care.

Table 41 - Survey Purpose, Context, and Population

Component	Description / Details
Survey title	Full formal title of the survey instrument
Date of deployment	Exact timeline or period of distribution
Research objective	Concise summary of what the survey aimed to investigate or document
Target population	Description of who was invited to participate
Inclusion criteria	Eligibility criteria for participation
Exclusion criteria	Criteria for omission of responses

The first section outlines the general framing of the survey instrument in terms of purpose, timing, and participant selection. Clearly defining the title, deployment date, and research objective ensures that the survey is situationally anchored within a broader analytical framework and situated historically in relation to fieldwork or reform processes (Fink, 2013). Detailing the target population and eligibility criteria not only enhances transparency but also aligns the work with sampling norms in medical and psychological research (De Vaus, 2013). In the context of mental health services research -particularly when conducted as action-research during structural instability -documenting inclusion and exclusion criteria also enables more robust interpretation of findings, including potential selection bias and representativity (Patton, 2015; WHO, 2021).

Table 42 - Recruitment, Distribution, and Ethical Safeguards

Component	Description / Details
Recruitment strategy	Channels and strategy used to reach respondents
Response rate and sample description	Number of responses and key characteristics
Ethical oversight and informed consent	Procedures for consent, anonymity, and ethics compliance

Component	Description / Details
Data management and security	How data were stored, anonymized, and who had access

This second cluster emphasizes ethical rigor and transparency in the recruitment and handling of sensitive participant information. Documenting the recruitment strategy -whether through professional networks, institutional mailing lists, COST Action platforms, or open calls -is crucial for evaluating the methodological soundness and replicability of the research (Nosek et al., 2015). The response rate and profile data contextualize the robustness and limitations of the findings, while the ethical protocols must detail how consent was obtained, privacy preserved, and any relevant approvals sought or waived. These steps are particularly critical in mental health research, where coercion and vulnerability have historically undermined ethical standards (Beauchamp & Childress, 2019; Fernando, 2014). The inclusion of data security protocols also reflects adherence to GDPR standards and reinforces trust in the scientific process, especially in open science contexts.

Table 43 - Technological infrastructure and methodological integrity

Component	Description / Details
Survey instrument	Type, structure, and components of the questionnaire
Technological platform and infrastructure	The platform used and rationale for its selection
Analytical approach	Analytical techniques used and coding procedures
Limitations	Declared methodological or infrastructural constraints

This third section of the methods employed centers on the technological and methodological integrity of the survey. Specifying the instrument's architecture -such as use of open-ended questions, Likert scales, or clinical vignettes -clarifies the epistemological grounding of the instrument and the type of knowledge it sought to elicit (Gobo, 2008; Moncrieff et al., 2013). The choice of platform (e.g., LimeSurvey, Microsoft Forms) must be justified in terms of accessibility, data protection, and compatibility with open science goals. The analytical strategy, whether thematic analysis, content coding, or statistical modeling, demonstrates methodological clarity and safeguards against epistemological opacity. Acknowledging limitations -such as spam filters halting distribution, as in your 2025 deprescribing survey -reinforces the scientific honesty expected under rigorous standards and reveals how institutional barriers can obstruct evidence generation even under ethical intentions.

Table 44 - Outputs, transparency, and research impact

Component	Description / Details
Open Science Compliance	Publication of protocols, data, metadata; FAIR principles adherence
Impact and Use of Findings	How results were or will be applied to policy or practice
Related Outputs	Publications, reports, or materials produced from the data

The final methodological grouping concerns the afterlife of the data: how knowledge is shared, used, and preserved. Compliance with open science standards -including preregistration, sharing of protocols, and publication of FAIR-compliant metadata -is increasingly expected in academic health research (Wilkinson et al., 2016; European Commission, 2020). Open dissemination of results not only enhances reproducibility but also allows affected communities and professionals to use the findings to foster change, particularly when respondents are invited to opt into follow-up projects.

Documenting the output -whether a journal article, thesis section, or policy briefing -ensures that the survey is not an isolated event but part of an evolving dialogue and structural reform effort. In action-research, impact is not an afterthought but integral to the design and intent of the method itself (Reason & Bradbury, 2008).

2.2.1. The Schizophrenia Label Inquiry in Spain

The first major survey informing this dissertation was the Spanish adaptation of the alleged Inquiry into the ‘Schizophrenia’ Label (ISL), originally coordinated in the United Kingdom by a distinguished team of survivors, professionals, and critical scholars including Professor Suman Fernando, Dr. Jayasree Kalathil, Dr. Philip Thomas, and Dr. Janet Wallcraft. This Inquiry was an unprecedented initiative to systematically document the personal, institutional, and social consequences of receiving a diagnosis of alleged schizophrenia, with the aim of exposing its damaging effects and questioning the legitimacy of its use in modern mental health systems (Fernando et al., 2014). The ISL was built through testimony-based research, inviting submissions from those with lived experience of the label, their families, and professionals across the United Kingdom. It was widely disseminated and remains a landmark in user/survivor-led knowledge production, combining deep epistemological insight with political urgency. The report had a transformative impact on public and academic discourse, helping to precipitate the International Society for the Psychological and Social Approaches to Psychosis (ISPS) decision to remove alleged schizophrenia from its name. It also helped consolidate a paradigm shift toward trauma-informed, rights-based, and culturally sensitive alternatives to diagnostic psychiatry.

Table 45 - Coordinating group of the inquiry into the original schizophrenia label, UK, 2014

Name		Role and Short Biography
Professor Suman Fernando		Psychiatrist and critical thinker in transcultural psychiatry. Worked in Enfield for over 20 years; later became Honorary Professor at London Metropolitan University. Served on the Mental Health Act Commission (1988–1995). Authored several key texts on race, culture, and mental health, including <i>Mental Health Worldwide</i> (2014). Recently passed away in 2023, leaving a profound legacy.
Dr. Jayasree Kalathil		Survivor researcher, writer, and founder of the Survivor Research collective. With personal experience of psychiatric services in India and the UK, she has published extensively on mental health, racialisation, and lived experience. Co-author of <i>Values and Ethics in Mental Health</i> , and editor of <i>The Sackcloth Man</i> , a children’s book. A leading voice in Mad Studies.
Dr. Philip Thomas		Former consultant psychiatrist and co-founder of the UK Critical Psychiatry Network. Retired from clinical practice, he continues to write on culture, power, and madness. Former chair of Sharing Voices Bradford. His work emphasizes the social and historical context of distress, advocating for alternatives to biomedical psychiatry. Currently writing a book on critical psychiatry.
Dr. Janet Wallcraft		Mental health service user, researcher, and activist. Holds a PhD on psychiatric hospitalisation narratives. Fellow at Birmingham and Hertfordshire Universities. Authored <i>On Our Own Terms</i> and <i>Healing Minds</i> . Her work has focused on self-management, complementary therapies, and user involvement in research. Brings a rich experiential and academic perspective to mental health reform.

The Spanish version of this Inquiry was launched and adapted independently by the present researcher during the early stages of postgraduate study, prior to the official beginning of this doctoral work, with input from members of the Spanish collective LoComún. We expanded the

number of question, adapting it to the Spanish reality. However, it was methodologically consistent and ethically aligned with the original effort, and became a central component of this dissertation's evidentiary base. The survey was distributed both online and by post, following open science principles and open-source technical implementation. Thousands of individuals across Spain - including professionals, survivors, users, and family members -were reached via a comprehensive distribution effort to almost all public mental health centers, support associations, some direct contacts, and most known activist networks.

This adaptation retained the testimonial richness and critical openness of the original Inquiry, with items focusing on the meaning of diagnosis, its perceived effects, the experience of coercion, and the perceived alternatives to current systems. It foregrounded the voices of those marginalized and criminalized by diagnostic practices, and thus contributed directly to the core aims of this research: exposing systemic violence, contesting the epistemological dominance of biomedical psychiatry, and advancing a model of shared decision-making and patient autonomy rooted in ethics, dignity, and justice.

This research honors the entire Co-ordinating Group of the original ISL for their visionary work. In particular, it expresses gratitude and profound respect to Professor Suman Fernando, a pioneer in critical and transcultural psychiatry, whose recent passing marks a deep loss for the global community. His legacy continues in every effort to decolonize mental health and center the lived experience of those most harmed by its systems.

2.2.2- Open dialogue professionals survey

The Open Dialogue (OD) model represents a paradigmatic reorientation of mental health care away from control, pathology, and coercion, and toward trust, shared meaning, and relational accountability. Originating in Western Lapland, Finland, it is now globally recognized not only for its clinical outcomes in psychosis but also for its ethical stance in psychiatric care (Seikkula & Olson, 2003; Buus et al., 2017; Razzaque & Stockmann, 2016). By centering dialogical interaction, network-based decision-making, and continuity of care, the OD model directly addresses the core concerns of this dissertation: the need for rights-based, non-violent, and transparent practices in psychiatry.

In the context of Spain, where overdiagnosis, overmedication, and systemic institutionalization remain widespread (Ramon et al., 2022; González et al., 2020), the OD model has emerged as both a therapeutic and sociopolitical alternative. It provides a culturally grounded and clinically viable framework for resisting coercion and fostering collective responsibility. Professional training in Open Dialogue began with pilot groups in Catalonia and later expanded to Andalusia, gaining formal support in several academic settings.

Before launching the present survey, our team actively participated in a national census effort led by HopenDialogue, a European project promoting dialogical practices across health systems (Pocobello et al., 2021). This census aimed to document all professionals, services, and informal initiatives linked to Open Dialogue in Spain. As part of that process, the researcher contributed a comprehensive list of contacts gathered over years of engagement -comprising hundreds of clinicians, educators, researchers, and activists who had expressed sustained interest in dialogical care. Through this participatory mapping, we reached nearly every professional in the country who had either trained in or supported the OD approach. The census established a baseline, documenting

the scattered but growing community of dialogically trained professionals and their placement within public and private services.

Building upon this foundational work, the Open Dialogue Professionals Survey was conceptualized as a second-stage empirical effort. Its objective was not simply to assess knowledge or compliance, but to explore the lived tensions, ethical obstacles, and latent potential of dialogical care within Spain's often rigid institutional landscape. It asked: What happens after the training ends? How do professionals navigate moral distress, institutional contradiction, and patient expectations in daily practice? The survey, designed and distributed in 2023, was structured around six thematic axes: (1) exposure to coercive practices in institutions; (2) fidelity to dialogical principles in practice; (3) ethical tensions and institutional resistance; (4) experiences with shared decision-making; (5) perceptions of patient voice and autonomy; and (6) systemic and legal barriers to transformation. A total of 35 questions -including multiple open-ended prompts -were included, allowing for qualitative and quantitative insight.

Dissemination occurred through open-source tools and under GDPR-compliant protocols, following ethical principles aligned with open science and participant protection. Informed consent was obtained at the outset. Participants were drawn from the HopenDialogue census contacts, Spanish Open Dialogue training alumni groups, and the national networks of professionals built through prior engagements. Seventy-six complete responses were collected and analyzed. Many participants extended their input through follow-up emails or calls, reinforcing the dialogical nature of the method itself.

The methodological foundation for this survey lies in medical anthropology and participatory action research. It acknowledges professionals not as neutral observers or technical executors but as embodied agents navigating structures of power, harm, and possibility (Rappaport, 2008; Holmes et al., 2006). By placing their testimonies at the center, the survey created space for epistemic reflection and for resisting the epistemological erasure common in hierarchical psychiatric cultures (Kalathil, 2011; Thomas & Bracken, 2007).

Open Dialogue itself is not simply a model to be measured; it is a methodological parallel to the survey and the thesis more broadly. It enacts shared meaning, recognizes the polyphonic nature of human experience, and treats speech as action (Bakhtin, 1981; Seikkula et al., 2006). In this sense, both the content and form of the research reflect OD principles: polyvocality, transparency, and a radical commitment to ethical presence.

Since the time of the survey, OD-related efforts have increasingly shifted from the Barcelona training nucleus to the University of Almería, where new institutional collaborations, public programs, and undergraduate curriculum integrations have emerged. This reflects a southward momentum in Spain's dialogical psychiatry landscape -mirroring the cultural, epistemic, and structural decentralization sought by the reform movement.

In the context of this dissertation, this survey provides not only data but direction. It confirms that real commitment to shared decision-making and ethical care already exists -but often without the structural support or cultural legitimacy it requires to thrive. The testimonies gathered show a field in tension, professionals caught between aspirations and betrayals, and a healthcare model struggling to evolve. The survey -like the OD model itself -reminds us that change begins with respect, strong ethical backbone and principles, due diligence, skilled team work, active listening, and immediate action in the right direction, avoiding all iatrogenic and services induced harm.

Establishing checks and balances, keeping corruption and incompetence at bay. The deliberate act of making visible what is otherwise left unsaid, ignored, or denied, particularly in relation to power, harm, and hierarchical status and structural violence of all sorts. Responsibility.

2.2.3 Shared decision-making, prescription, and deprescription survey

This third and final major survey conducted within the framework of this dissertation offers perhaps the most comprehensive and policy-relevant insight into contemporary psychiatric practices in Spain. Designed during one of the most vulnerable periods in the researcher's life -recovering from institutional and familial violence, transitioning from homelessness, and under constant threat -the survey stands as a testament to the resilience of science conducted under duress and to the determination to contribute meaningfully to mental health reform. Despite the hostile circumstances, a scientifically rigorous methodology was maintained, with content rooted in the best available evidence and international ethical standards for medical research (Beauchamp & Childress, 2019; WHO, 2021).

The survey, titled *Shared Decision-Making and Medication Use in Psychiatry: Patient Autonomy and Well-Being*, was developed and distributed in 2025 using Microsoft Forms, the official platform of the Universitat Rovirathe researcher Virgili. While this institutional tool was selected for reasons of compliance, accessibility, and data protection within the university framework, it ultimately proved ill-suited to the demands of large-scale professional research. Microsoft's system triggered anti-spam mechanisms after an initial wave of dissemination, halting further outreach and severely limiting the scope of distribution. This technical failure is emblematic of a broader institutional neglect of open science standards, revealing the gap between rhetorical support for academic excellence and the practical absence of infrastructure to facilitate meaningful, socially engaged research. The choice to use a proprietary platform rather than an open-source alternative -such as LimeSurvey, previously used by the researcher -was dictated not by scientific reasoning, but by the university's policy environment and the researcher's inability to fund independent hosting due to the severe financial constraints endured during and after institutional abuse.

This context must be understood as part of the method itself. The researcher was, at the time, emerging from a prolonged state of institutional and domestic violence, homelessness, and economic destitution, while continuing professional engagement and academic production. The lack of support for safe working conditions, technical resources, or ethical accompaniment reflects the structural contradictions of academic systems that formally promote field engagement, public health advocacy, and lived experience integration, Yet, materially obstruct the researchers who attempt to enact them under adverse conditions. This is not simply a logistical failure; it is an ethical and epistemological one. The compromised distribution impacted response rates -only around a hundred professionals completed the survey -but not the quality of the data. Those who did respond did so with exceptional depth, often dedicating up to two hours to reflect on questions that integrated medical evidence, ethical reasoning, and real-world practice. The richness of these responses confirms the survey's scientific value, but also highlights what was lost due to structural negligence and institutional rigidity.

Thus, the survey does not merely gather data: it embodies the conditions under which evidence is possible. It exposes the fragility of academic systems that rely on goodwill, volunteerism, and personal resilience while offering minimal operational support for research that critically addresses

systemic violence. In this sense, the survey is also a case study in academic precarity and the unacknowledged risks borne by action-researchers working to improve public mental health services. The reliance on personal initiative and minimal infrastructure contrasts starkly with the potential scope of such work if supported adequately. Moving forward, a transition toward open-source infrastructure, institutional guarantees of ethical protection, and properly resourced fieldwork platforms is imperative -not only for methodological integrity, but for the very survival of those producing transformative research.

Table 46 - Structure of the 2025 survey on shared decision-making and medication use

Section	Description
1. Respondent Profile	Collected data on participants' professional background, institutional affiliation, clinical roles, and experience in mental health care.
2. Clinical Stances	Explored attitudes and practical experience related to deprescribing and shared decision-making. Included scenario-based reflection on conditions such as psychosis, dementia, trauma, and institutional care.
3. National Policy Implementation	Assessed systemic barriers and enabling conditions for implementing non-coercive, evidence-based medication review and deprescribing practices at scale.
4. Open Feedback and Future Engagement	Invited respondents to join professional training networks, receive results, and participate in the co-creation of best practice protocols for ethical psychiatric care.

The respondents contributing invaluable experiential knowledge from across Spain's diverse mental health system. The questions were carefully formulated to gather insights not only about theoretical stances but about what is actually done, what should be done, and why certain reforms succeed or fail in practice. In that regard, the survey offered a bridge between front-line knowledge and structural diagnosis (Mol, 2008; Gabbay & Le May, 2011).

The content of the survey drew directly from the lived experience of the researcher and from five years of ethnographic fieldwork, integrating lessons from previous national and international surveys, trauma-informed care principles, and critiques of biomedical reductionism (Moncrieff et al., 2010; Read & Dillon, 2013). It also echoed international recommendations calling for reduced reliance on psychotropics, especially neuroleptics, and emphasized the clinical, ethical, and social dimensions of medication practices in psychiatry (Foster, 2022; WHO, 2021).

In line with the objectives of the thesis, this survey did not merely document opinions but served as an intervention in itself: a process of prompting institutional reflection, networking among professionals, and reasserting the role of care ethics and human rights in psychiatric practice (Tronto, 1993; Honneth, 2012). By inviting participants to opt in to receive results, training, and collaboration opportunities, the survey also strengthened the foundations for the deployment of the mental health section of EU BEACON One Health Education COST action, and other related projects such as SocialMent, dedicated to enhancing autonomy and ethical practice in Spain.

The timing of this survey was deliberately aligned with the broader public and institutional debate surrounding the Spanish National Mental Health Strategy 2022–2026, which by early 2025 was in its final review and implementation phases (Ministerio de Sanidad, 2022). At the heart of this national plan was an explicit commitment to deinstitutionalization, rights-based care, patient autonomy, and deprescription of psychiatric drugs where safe and appropriate. These policy priorities resonated deeply with the focus of the present study and its epistemological grounding in

biocultural action-research. The survey thus served both as a diagnostic tool -measuring the degree to which these values and strategies were already present or resisted within clinical practice -and as a participatory contribution to the reform process itself.

Table 47 - Hypothetical reform scenarios in the 2025 survey, methodological purpose

Scenario	Description	Purpose in Survey Methodology
1. Implementing national screening for gluten sensitivity in psychiatric diagnoses	Presents an emerging evidence-based intervention requiring reconsideration of psychiatric diagnoses in light of dietary factors.	To evaluate professionals' readiness to integrate somatic screening and dietary alternatives into psychiatric decision-making, and to assess perceived feasibility of non-pharmacological treatment pathways.
2. Deprescribing neuroleptics in cases of missed metabolic and nutritional disorders	Highlights the consequences of diagnostic overshadowing and lack of interdisciplinary screening in psychiatry.	To explore professional attitudes toward medical coordination in deprescribing, and the structural readiness for diagnostic re-evaluation based on physiological assessments.
3. Addressing psychiatric abuse cases uncovered through national research on mental health and violence	Exposes the systemic neglect of trauma and the iatrogenic harms caused by inappropriate psychiatric labeling.	To assess awareness of institutional violence and the ethical dimensions of shared decision-making in contexts of historical abuse, including views on trauma-informed reform and reparation.
4. National deprescribing initiative for elderly patients at high risk of mortality and disability	Focuses on the risks of neuroleptic use among elderly populations and WHO-backed deprescribing imperatives.	To capture clinical insight into age-specific deprescribing protocols, safety concerns, and professional responsibility in contexts of vulnerability and risk mitigation.
5. Reevaluating long-term psychiatric diagnoses in a national audit	Questions the validity of long-term psychiatric labeling and the inertia of chronic pharmacological treatment.	To examine respondents' views on re-diagnosis, historical error correction, and the ethics of long-term medication dependency based on outdated clinical assumptions.
6. Addressing the overprescription of neuroleptics in social care and marginalized communities	Highlights structural inequalities in medication practices for socially excluded populations.	To gauge professional sensitivity to systemic discrimination in prescribing patterns and the capacity of services to shift toward equitable, community-based alternatives.
7. National review of the use of neuroleptics in children and adolescents	Addresses developmental and ethical risks in pediatric neuroleptic use, often without sufficient differential diagnosis.	To document professional stances on deprescribing in young populations, perceived risk-benefit ratios, and the educational, familial, and systemic supports required for safer transitions.
8. Ending the use of neuroleptics for non-psychiatric indications in general medicine	Challenges routine but clinically inappropriate neuroleptic use in general hospital and somatic care contexts.	To assess inter-specialty communication, guideline awareness, and mechanisms for error correction and deprescribing in non-psychiatric settings.

The eight scenario-based items presented in Section 2 of the survey were selected and formulated to mirror both existing clinical controversies and anticipated challenges posed by national-level reforms. For instance, the proposed gluten sensitivity screening draws on recent biomedical literature highlighting the neuropsychiatric impact of celiac and non-celiac gluten sensitivity (Jackson et al., 2012; Lionetti et al., 2015), while testing participants' openness to non-

pharmacological and dietary interventions that require systemic change. Better screenings are much needed, as each can save lives. This scenario highlights the need by providing an example many, even if few, still feel silly about -that is concerning, as the number of substances and life events that lead to mimicking the symptoms traditionally considered as a clear sign of a severe mental health condition by some practitioners, is alarmingly high -from spiking to food poisoning, violence, and the longest list requiring careful attention beyond the current few minutes at a glance and mostly ill used tests to justify without even considering any other option, but to reinforce the held beliefs. The decisions made change the course of lives forever, unless checked properly. Reality check lists are needed, thus this as method to remind all professionals. Similarly, the scenario on undiagnosed metabolic and nutritional disorders challenges the widespread diagnostic overshadowing found in Spanish psychiatry and foregrounds the need for interdisciplinary coordination between primary care and mental health -a known weak point in the current system (Arango et al., 2021).

Perhaps most politically salient was the scenario on psychiatric abuse and trauma misrecognition, which prompted respondents to grapple with the structural violence embedded in routine care. This question was directly inspired by growing international and Spanish literature on institutional betrayal in psychiatry (Read et al., 2008; Kalathil, 2013) and tied into the Ministry's emerging emphasis on trauma-informed approaches and post-coercion recovery pathways. Respondents were invited to consider not just the technical aspects of deprescribing, but also the institutional responsibilities and reparative frameworks necessary to undo past harm -thus expanding the very scope of what is commonly considered psychiatric care.

The tempo of the survey -distributed during a narrow window between February and May 2025 -reflected both strategic timing and urgent constraints. It was launched shortly after the final national consultation meetings and just before the Ministry of Health began formalizing its updated implementation plans. Key members of the policy taskforce expressed direct interest in the findings, and several professionals responded with explicit references to the National Mental Health Strategy, affirming the survey's relevance and urgency. the format and wording of each scenario were intentionally designed to be forward-compatible with potential policy instruments, ensuring that the answers would have interpretive and planning value not just for academia, but for health governance, training institutions, and legal review. The instrument is set to be further improved and adapted, redeployed in other countries and Spain anew, translated to fit regional needs, shared it all as open source under a free license, in a free public repository ready to be localized and run.

This survey represents a methodologically rigorous, epistemologically grounded, and policy-attuned intervention at the intersection of science, lived experience, and institutional change. It captures not only professional attitudes, but the emerging fractures, ethical debates, and practical constraints of a mental health system in transition. Its value lies not only in what it records, but in what it prompts - reflection, dialogue, and coordination among those tasked with building a safer, more effective, and more human mental health system.

2.2.4 Reflection on survey methodology in mental health and anthropology

Survey methodology in the context of psychiatry and medical anthropology requires more than technical precision; it demands epistemic humility, ethical reflexivity, and contextual sensitivity to the historical violence, institutional asymmetries, and power-laden dynamics that structure both psychiatric care and social research. Each of the three surveys included in this dissertation was

designed not simply to gather data, but to document situated knowledge, generate reflection, and engage professionals in collective reappraisal of practices often shielded by clinical authority or bureaucratic inertia. The very act of surveying -especially on topics such as coercion, diagnostic validity, and shared decision-making -constitutes an intervention in itself, capable of both unsettling and reorienting established frames of reference. In mental health, the positionality of the researcher is never neutral, and even less so when the researcher is also a survivor, a clinician, and an educator embedded within the systems being studied (Gobo, 2008; Haraway, 1988; Fernando, 2014). Thus, the methodological design of each instrument incorporated not only clear operational constructs and evidence-informed questions, but also space for narrative elaboration, dissent, uncertainty, and critique. The balance between structured and open-ended content was crucial to allow for nuanced engagement, mitigating the epistemological violence often reproduced by instruments that reduce complex moral realities to binary answers or quantifiable attitudes (Tronto, 1993; Flick, 2018; Patton, 2015).

The implementation of these surveys under conditions of systemic adversity -personal precarity, institutional obstruction, and the collapse of protective mechanisms -offers a necessary critique of academic norms that presume stable environments for ethical research. While most survey design frameworks emphasize clarity of language, pretesting, and balanced item construction (De Vaus, 2013; Fink, 2013), few account for the sociopolitical hostility and infrastructural void faced by action-researchers working on contested terrain. The breakdown of Microsoft Forms due to algorithmic spam detection, for instance, illustrates not only a technological limitation but a broader failure of institutional foresight in enabling open, researcher-led inquiry. In the face of such structural neglect, the very collection of responses -often from professionals overburdened by austerity, bureaucratic micromanagement, or clinical despair -becomes a demonstration of solidarity and commitment to transformative knowledge (Moncrieff et al., 2013; WHO, 2021). The surveys, therefore, must be read as partial archives of possibility and resistance. Their limitations, including lower-than-expected response rates, are not evidence of methodological failure but of the urgent need for supportive infrastructures, decentralized research tools, and scientific culture attuned to the burdens borne by those who research from within sites of suffering (Mol, 2008; Reason & Bradbury, 2008). Each data point is a relational accomplishment, enabled by trust, resonance, and often years of dialogue-building and credibility work in the field.

The survey methodology employed foregrounds a model of ethical co-production and applied anthropology that stands in contrast to extractive or merely descriptive approaches. These surveys are not isolated instruments but integral components of a wider action-research project rooted in lived experience, structural critique, and the commitment to advance dignity-affirming mental health systems. They reflect a methodological praxis where the scientific, ethical, and political dimensions of inquiry are inseparable. Each instrument sought to extend not only knowledge but also dialogue -horizontal, situated, and potentially emancipatory. The methodological reflections offered in this section should guide future efforts not merely to replicate but to deepen these approaches, insisting on the role of anthropology and biomedicine not as neutral observers but as active agents in the production of more just, reflective, and responsive psychiatric care. Open science standards -ranging from the FAIR data principles to the transparency of survey protocols - must be institutionalized, not suggested; professional engagement should be valued as knowledge creation, not incidental feedback; and surveys must be understood as ethical-political acts as much as methodological tools (Wilkinson et al., 2016; European Commission, 2020; Nosek et al., 2018).

This is desperately required for research on mental health move beyond flawed metrics and models, from abusing methods, skewed toward corruption and crime, toward the needed paradigm shift.

2.3 Fieldwork and participant observation

The core of this dissertation rests on a longitudinal, transnational, and action-oriented ethnographic engagement conducted between 2020 and 2025, framed within the intersecting crises of psychiatric violence, institutional inertia, and epistemic injustice. The fieldwork unfolded across multiple countries and institutional contexts, often under conditions of direct threat and systemic abandonment. Rather than following a classical anthropological model of immersion in a single locale, the methodological design pursued a distributed and participatory approach, aligning with the principles of critical medical anthropology (Scheper-Hughes, 1992), activist ethnography (Speed, 2006), and action-research grounded in biocultural vulnerability (Singer et al., 2017). Each activity was selected based on its strategic relevance for understanding, contesting, and transforming coercive practices in mental health systems. The field sites included networks of resistance, policy initiatives, educational platforms, and institutional reform spaces. The following subsections detail each engagement, from its inception and purpose to its methodological contribution. The documentation and analysis of fieldwork in this dissertation adheres to high scientific, ethical, and epistemological standards that go beyond conventional descriptions of research activity. In line with recent advancements in anthropological, medical, and action-research methodologies, each fieldwork undertaking, institutional engagement, and academic mission has been systematically reported using a comprehensive template designed to ensure full transparency, traceability, and accountability (Ellis et al., 2011; Scheper-Hughes, 1995; Beauchamp & Childress, 2019). This structured approach meets emerging demands for reproducibility, contextual specificity, and ethical reflexivity in critical mental health research (Fricker, 2007; Puertas & Costa, 2021).

The reporting template is divided into four interrelated sections, each capturing distinct Yet, complementary dimensions of the research process. The first table documents the operational role and institutional positioning of the researcher, allowing for comparative tracking of responsibilities, partnerships, and declared outputs across fieldwork contexts. The second addresses methodological framing and data collection, capturing not only the tools used but also the logic of engagement, duration, and relevance to the dissertation’s aims. The third covers ethical protocols and epistemic positioning, with specific attention to the embedded nature of the researcher within systems of violence, trauma, or structural vulnerability -key features in psychiatric ethnography and survivor-led knowledge production (Kalathil et al., 2022; Russo & Beresford, 2015). The final section deals with systemic constraints, open science principles, and observed impacts, acknowledging that the context of participation -including institutional obstruction, funding limitations, or legal threats -critically shapes what research is possible, how it is interpreted, and whom it benefits (Hess, 2007; Strathern, 2000).

Table 48 - General identification and operational role

Field	Description
Activity Name	Title or short name of the fieldwork or engagement
Time Frame	Duration

Field	Description
Geographic Location(s)	Country/region or institutional site(s) involved
Institutional Affiliation	Official partner institution(s) or network(s)
Researcher Role	Main role assumed
Co-authors or Collaborators	Individuals, institutions, or networks involved, if any
Reported Output	Related deliverables, reports, publications, or dissemination format

This multidimensional structure supports the dual function of fieldwork in this dissertation: as both data source and lived intervention. The principle guiding its deployment is one of *situated accountability* (Haraway, 1988): the recognition that all knowledge is produced within power-laden, historically situated relationships. For this reason, each mission is not only described but *contextualized*, with metadata on how it was implemented, who participated, what barriers were encountered, and what outcomes -material or symbolic -ensued. In doing so, the methodology honors the call for participatory, emancipatory frameworks in health research that foreground experience, respect community knowledge, and seek structural transformation (Cornwall & Jewkes, 1995; Tronto, 1993). This template will be systematically applied to every mission, including COST Action participations, teaching roles, institutional stays, policy contributions, and ethnographic immersion. Each will be inserted within the broader analytical architecture of the thesis, reinforcing both scientific coherence and ethical legitimacy.

Table 49 - Methodological framing and implementation

Field	Description
Research Aim or Question	Central research purpose or hypothesis
Methods Employed	Types of methods used (e.g., ethnographic observation, facilitation, qualitative documentation)
Data Collected	Nature of collected data (e.g., fieldnotes, testimonies, institutional feedback, audiovisual material)
Mode of Engagement	On-site, remote, hybrid, or document-based
Integration with Thesis	How this mission contributes to the dissertation aims and chapters
Duration and Frequency	Estimated number of sessions/days and regularity of engagement

Table 50 - Ethical and Epistemic Considerations

Field	Description
Ethical Protocol	Ethics approval status and protocol references, if applicable
Lived Experience Consideration	Role of researcher's positionality and experiential knowledge
Power Dynamics and Reflexivity	Noted asymmetries, conflicts of interest, or identity-based influences
Consent and Participation	Mode of informed consent and safeguarding of participants
Epistemic Justice Measures	Measures taken to center marginalized knowledge and plural perspectives

The method adopted to account for the actions taken during this research is grounded in a praxis of scientific witnessing under duress -a never sought after, nor asked form of situated action-research

that integrates survival, resistance, and documentation in conditions of extreme structural and interpersonal violence. Within the field of mental health, this approach is not merely a methodological choice but an epistemological necessity: when the researcher is simultaneously the target of psychiatric abuse, institutional betrayal, and domestic persecution, the very act of documenting becomes both evidence generation and a refusal of erasure. Following the logic of militant ethnography (Scheper-Hughes, 1995) and the epistemic justice frameworks proposed by Fricker (2007) and Russo & Beresford (2015), the recording of each mission -however interrupted or precarious -constitutes a data point in the analysis of how systems harm, obscure harm, or enable healing. The ability to carry out these actions while suffering from documented crimes, homelessness, threats, and lack of institutional support further validates the relevance of the findings: they emerge not from detached observation but from embodied, scientifically mediated endurance. This dual positionality enables the capture of knowledge otherwise invisible to dominant metrics, legitimizing alternative forms of rigour that center moral accountability, empirical granularity, and life-preserving intent.

Table 55 - Contextual Constraints, Open Science and Impact

Field	Description
Structural barriers	Limitations due to institutional, political, or technical conditions
Trauma/violence context	Any role of personal risk, institutional violence, or domestic abuse impacting the work
Open science compliance	Whether protocols, data, or materials were made openly available
Documentation format	Fieldnotes, video/audio, reflexive memos, code repositories, etc.
Observed impact	Tangible or intangible outcomes, stakeholder feedback, institutional change, community mobilization
Dissemination path	Whether outputs were shared publicly, through networks, or with policy makers

The engagements are categorized on its online versus offline nature. The first table lists those that relied entirely on digital infrastructures, reflecting the methodological evolution of ethnography toward distributed, digitally mediated fieldwork. These activities demonstrate how critical psychiatry networks, COST Actions, and mental health reform efforts can be mapped and influenced remotely. The shift to digital settings has been deeply analyzed within digital anthropology and mental health research (Pink et al., 2016; Horst & Miller, 2012), and this work aligns with those frameworks while maintaining a firm ethical grounding. Virtual ethnography, liaison coordination, and collaborative governance -particularly during the pandemic -offered both challenges and opportunities for tracking epistemic injustice, advocating for best practices, and supporting emerging infrastructures of care (Fricker, 2007; Topór et al., 2020).

Digital Fieldwork Engagements

Date	Activity	Description
2022–2025	ReMO Virtual Ethnography on Mental Health Expert Systems	Conducted structured digital observation and analysis of ethical algorithms and clinical automation.
2025	CliMent COST Action	Contributed to protocol review and governance discussions on ethics in clinical mental health practice.
2025	Youth Digital Mental Health COST Action	Developed survey instruments, theoretical framing, and prevention strategies within digital youth contexts.

The mixed-mode fieldwork engagements involved a blend of in-person and online methods, reflecting the hybrid nature of many current transnational research collaborations. Mixed-mode participation combines the relational depth of embodied encounters with the scalability of digital methods. This duality requires particular methodological attention to continuity, contextual fidelity, and cross-modal validity (Beaulieu, 2010; Lupton, 2020). In these COST Actions and institutional partnerships, the researcher performed a variety of roles -from governance to observation -while documenting both face-to-face and virtual engagements, generating data across interlocking spaces of influence.

Mixed-mode fieldwork engagements

Date	Activity	Description
2020–2022	Coordinator of the spanish open dialogue network	Led national network on dialogic psychiatry reform through digital forums and documentation.
2020–2022	Mad in america global network liaison	Coordinated survivor testimony, critical psychiatry networks, and transnational digital ethnography.
2020–2024	ReMO COST Action	Documented epistemic injustice and researcher vulnerability in hybrid academic environments.
2020–2024	FOSTREN COST Action	Participated in coercion reduction initiatives and working groups via online and on-site events.
2021–2025	EU BEACON One Health Education COST Action	Co-founded and led transdisciplinary network integrating policy, ethics, and open science in mental health.
2025	Visiting Scholar, Universitas Muhammadiyah Yogyakarta (UMY), Indonesia	Conducted cross-cultural ethnography on pasung, taught mental health ethics, and maintained international digital communication.

The in-person fieldwork engagements required direct, embodied presence within clinical, educational, or policy settings. In-person fieldwork continues to be central to medical and psychological anthropology, allowing deep contextual immersion and multisensory engagement (Ingold, 2014; Good, 1994). The researcher here engaged in formal training, observational practice, and symposium organization while documenting critical aspects of mental health reform, trauma, and institutional violence. Such engagements allowed for the co-construction of meaning with stakeholders, active witnessing, and narrative co-production under challenging and often oppressive conditions.

In-person fieldwork engagements

Date	Activity	Description
Aug–Sep 2022	Fieldwork in Trieste, Italy (World Health Organization-recognized model)	Immersive observation of community-based, non-coercive psychiatry.
2021	Teaching at University of Almería (Inclúyete Program)	Dialogic pedagogy and mental health awareness in formal academic settings.
2021	Open Dialogue Training	Participatory coordination and observation of

Date	Activity	Description
	(Barcelona)	structural resistance within a public university.
2021	Open Dialogue National Conference Organization	Organized and facilitated Spain's main event promoting dialogic psychiatry.
2022	ISPS Conference Presentation	Shared national data and professional resistance narratives in public academic forum.
2023	WPA Congress and Political Abuse Seminar Series	Curated survivor narratives and presented findings on systemic psychiatric harm.
Jan–Nov 2023	Global Symposium on Political Abuse of Psychiatry	Designed and coordinated a multi-format event exposing psychiatric repression.

The following subsections -2.3.1, 2.3.2, and 2.3.3- present a structured categorization of the researcher's fieldwork activities, organized according to modality: digital-only, hybrid mixed digital and in-person, and exclusively in-person engagements. This tripartite division reflects the methodological adaptations necessitated by both the nature of the research contexts and the constraints imposed by global events such as the COVID-19 pandemic, institutional restrictions, and ongoing personal risk. Rather than grouping activities thematically or geographically, the selected approach prioritizes the mode of engagement as a core epistemological variable, shaping access, interaction, and observational depth (Lupton, 2020; Pink et al., 2016). This method aligns with contemporary anthropological and sociological standards recognizing digital ethnography, hybrid participation, and embodied field immersion as distinct, valid forms of knowledge production (Beaulieu, 2010; Horst & Miller, 2012).

Each section is structured using a consistent reporting template that enables comparative analysis and methodological transparency. This includes specifying dates, roles, objectives, documentation techniques, and measurable impact for each activity. Such systematic tabulation adheres to open science and research integrity principles, allowing external audit, replication where appropriate, and critical reflection on the positionality of the researcher (Fricker, 2007; Nind, 2017). Reporting the fieldwork in this manner also meets increasing demands in transdisciplinary health research to foreground not only the content of knowledge but also the conditions under which it is produced - particularly under structural duress, epistemic injustice, or personal vulnerability (Topór et al., 2020; Gill & Donaghue, 2016). Ultimately, this methodology reinforces the rigor of scientific accountability in mental health research that incorporates lived experience, critical reflection, and field-based action.

2.3.1 Digital-only fieldwork engagements

The table above presents the core digital-only fieldwork engagements undertaken between 2020 and 2025, grounded in feminist and biocultural methodologies and executed under extreme constraints, including lockdown with abusers, lack of institutional support, and survival amidst systemic violence. Each row corresponds to an action-research initiative performed virtually due to pandemic conditions, parental care obligations, and international collaboration needs. Feminist epistemologies -especially those acknowledging the ethics of care (Tronto, 1993; Puig de la Bellacasa, 2017) - require full recognition that caregiving duties, structural violence, and embodied positionalities are not peripheral to scientific inquiry but foundational to its integrity. Building on this foundation, the digital ethnographic engagements were not merely adaptive responses to adversity but deliberate

methodological choices reflecting a situated ethics of presence and relational accountability. Anchored in medical anthropology, these practices foregrounded the entanglement of researcher and field, where vulnerability, care, and resistance became both objects and conditions of inquiry. Rather than framing digital interactions as lesser forms of data collection, this work acknowledged their potential to capture the affective intensities, narrative ruptures, and power asymmetries that structure psychiatric and caregiving systems. Platforms became contested terrains of visibility and invisibility, of voice and silencing, requiring constant negotiation of consent, boundaries, and recognition. Researcher reflexivity was not abstract but enacted in real time through embodied witnessing, trauma-informed engagement, and the strategic use of narrative to counter institutional erasure. In this sense, each digital fieldwork trace, chat logs, recorded interviews, shared documents, message threads, became both artefact and testimony, woven into a fabric of emancipatory, transcontextual, and politically committed research.

Table 56 - Online fieldwork engagements, general overview

Activity	Description	Methodological Approach	Observed or Projected Impact
ReMO COST Action, virtual ethnography	Ongoing ethnographic mission to learn from, and help disseminate, the work of health and mental health expert systems developed, old and now	Both literature review, and virtual ethnographic exploration of sources of knowledge in this area; interviews and presentations with experts	This mission must inform the work on other projects, such as a tutor-carer developed under the auspice of EU BEACON, and the laying down of best practices in Youth DMH.
CliMent COST Action (early phase)	Contributed remotely to the scientific and ethical framing of clinical mental health reform in Europe. Participated in the review of initial protocols, theoretical frameworks, and agenda setting.	Environmental, ecological approach. One Health applied to mental health. Early shaping of new COST Biophilia and the healing properties of natural environments, from a psychological, physiological and molecular level.	Early shaping of new COST initiative focused on clinical ethics and rights-based mental health care; extended existing EU collaborations.
Youth Digital Mental Health COST Action	Participated in early working groups of new COST Action focused on digital prevention strategies in youth mental health. Supported framing of educational and civic resilience approaches.	Digital fieldwork in education, co-design of youth-oriented prevention frameworks, interdisciplinary policy work. Emphasis on youth rights and the ethics of digital health surveillance.	Expanded transdisciplinary work into youth mental health; aligned digital ethnographic findings with broader prevention-oriented systems design.

In this case, the impossibility of professional detachment served not as a limitation but as an epistemological lens. Methodological honesty demands situating the researcher's full living condition within the scientific narrative. Choosing coworking spaces, libraries, and late-night hours to protect one's children while building global mental health initiatives is not a footnote but the method itself. These digital engagements -far from secondary -were the only feasible mode of international knowledge production under violent constraint. Yet, they generated substantial impact: building networks, shaping policy, and feeding into supranational reforms. This relational labor,

usually feminized and invisibilized, is here made central to the account of methods, in alignment with One Health principles that recognize the indivisibility of social, bodily, and ecological systems (Horton et al., 2014; WHO, 2021).

Despite the breadth of engagement and innovation achieved through these digital fieldwork modalities, the methodological process was severely constrained by systemic violence and infrastructural neglect. The researcher endured prolonged institutional and domestic abuse, resulting not only in personal trauma but in the near-total loss of scientific documentation. All primary data not explicitly backed up -fieldnotes, email records, community archives, and virtual networks cultivated across years -were irreversibly destroyed due to financial precarity and lack of institutional support. The digital knowledge base constructed collaboratively with hundreds of professionals and survivors, many of whom were dependent on these connections for ongoing reform efforts, was dismantled through platform failures triggered by unpaid service thresholds, academic email inaccessibility, and storage limitations. These constraints were not accidental. They reflect broader epistemic injustices whereby those most exposed to violence, and most committed to structural improvement, are denied the tools and safeguards necessary to sustain their work (Fricker, 2007; Kidd et al., 2022). Participant action research rooted in the suffering and resistance of survivors -those often pathologized, discredited, or prematurely killed by systemic cruelty -depends on sustained technical and institutional care, not precarious self-sacrifice and suffering.

The inability to maintain even a basic digital infrastructure -laptops, servers, stable cloud storage -while leading significant research actions illustrates the fragility of ethical science under coercive conditions. Only one physical folder containing essential documents was retained over the years of homelessness and persecution, surviving as the last material trace of hundreds of notebooks, datasets, collaborative outputs, and personal libraries erased by the conditions of abuse. This systemic failure not only disrupted academic continuity, but also harmed those depending on the researcher's work to build safer, more compassionate services. The intellectual, emotional, and strategic labour invested by colleagues, survivors, and professionals within these networks was extinguished by an environment where survival itself was at stake, and no meaningful protection was offered. The repercussions of such destruction extend far beyond one researcher, reverberating across scientific and civic communities that relied on continuity and visibility to consolidate change (Moncrieff et al., 2022; WHO, 2021).

Going forward, it is imperative that institutions adopt robust mechanisms for scientific protection, data redundancy, and emergency academic continuity plans -not just for reputational science, but for any and all research that embodies the ethics of care, urgency, and transformation. Everyone needs to be working safe, in the field, the laboratories, the classrooms, the hospitals, community health centers, and elsewhere.

The EU BEACON One Health Education COST Action, to which this thesis contributed my work as founder, brining it up from scratch despite the harshness of violence, aims to help catalyze this structural and cultural shift from the educational school and families with children system up. The researcher's inability to establish protective organizations or institutional platforms during the period of distress speaks to the depth of the systemic abandonment and material sabotage endured. Nevertheless, the survival of this work, despite the overwhelming obstacles, stands as both scientific and moral testimony to what is possible when research is anchored in truth, justice, and

the shared imperative to eliminate institutional harm. As long as the perpetrators -whether individual or institutional -do not succeed in extinguishing this trajectory, the collective transformation envisioned will remain viable, and every remaining opportunity will be used to rebuild, reconnect, and continue. Scientific knowledge cannot remain in armchairs if it is to uphold its public and ethical mission (Tronto, 1993; Honneth, 2012; Horton et al., 2014).

Section 2.3.2 - Mixed fieldwork engagements

Unlike fully digital undertakings or traditional in-person ethnography, a significant part of this dissertation's methodological architecture rests on mixed fieldwork engagements, combining remote participation with episodic physical presence when feasible. The engagements reported in this section, including sustained contributions to the ReMO and FOSTREN COST Actions, co-leadership of the EU BEACON One Health Education network, and the visiting scholarship at Universitas Muhammadiyah Yogyakarta (UMY), were undertaken during a period of acute personal duress and global constraint. The COVID-19 pandemic played a crucial role in shaping the hybrid nature of these engagements. Institutional infrastructures defaulted to digital spaces, and most collaborative work -both logistical and intellectual -was carried out online. Meetings were far and few in between, and physical participation, when possible, was limited by both public health restrictions and the author's precarious situation, tied to caregiving obligations and the need to remain in a protective stance against recurrent domestic violence.

Table 57 - Mixed fieldwork engagements, general overview

Activity	Description	Methodological Approach	Observed or Projected Impact
Mad in America Global Network Liaison	Coordinated international survivor-led networks, comparative mapping of coercion, resilience, and reform efforts globally. Participated in virtual forums and advocacy panels.	Digital ethnography, grounded participant observation of document analysis. Feminist and decolonial epistemologies applied to survivor knowledge and transnational solidarity networks.	Strengthened international lens on violence; psychiatric survivor expertise integrated into scientific mapping; built solidarity-based epistemic community.
Coordination of the Spanish Open Dialogue Network	Built and sustained national network of Open Dialogue professionals. Co-developed ethical guidelines, supported interregional communication, created database of practitioners.	Virtual coordination, collaborative ethnography, ethical design of clinical communication. Reflexive accountability applied to distributed reform movements.	Enabled national community of practice; supported institutional attempts at Open Dialogue diffusion; built lasting archive of practitioner resistance to coercion.
ReMO COST Action	Engaged in the alleged Researcher Mental Health Observatory network to document structural risks, mental health inequalities, and epistemic injustice across European academia.	Online plenary sessions, working group participation, institutional ethnography, digital memoing, consensus-building documents	Influenced policy recommendations on researcher mental health, produced critical reflections on structural barriers to early-career well-being
FOSTREN	COST Supported European	Comparative case study	Provided insights on

Activity	Description	Methodological Approach	Observed or Projected Impact
Action	coordination to reduce coercion in mental health services; mapped implementation fidelity, distortions of good practices, and resistance to non-coercive reform.	methods, online collaboration, protocol analysis, document-based observation	national variability, risks of reform co-optation, and strengthened the theoretical basis for anti-coercion clinical practices
EU BEACON One Health Education COST Action	Co-founded and directed dissemination for EU BEACON, integrating education, technology, and ethics for non-coercive mental health transformation across planetary and intergenerational dimensions.	Hybrid coordination, transdisciplinary forces, ethnography, science and workflows	field Facilitated multi-country cooperation, produced open-access repositories, digital supported the conceptual and technological basis for One Health education in psychiatry
Visiting Scholarship at Muhammadiyah University Yogyakarta (Java, Indonesia)	Ethnographic and teaching stay in Universitas Muhammadiyah Yogyakarta, combining comparative study on pasung (coercion/confinement) with curriculum design and student engagement.	Hybrid teaching-research model, cultural immersion, participant observation, oral history, trauma-informed interviews	Contributed to transnational discourse on coercion, reinforced One Health and Islamic psychological approaches to dignity-based mental health reform in Southeast Asian contexts

The hybrid model enabled participation despite structural adversity, but it also exposed profound asymmetries in resource access and epistemic visibility. As Tronto (1993) and Honneth (2012) argue, the ethics of care and recognition must extend beyond rhetoric to material support. In practice, no logistical support was provided by the home institution for field mobility, coworking spaces, or access to technological equipment -forcing the researcher to pay out of pocket or rely on public libraries during homelessness and economic destitution. The acts of presence, both virtual and on-site, were sustained through resilience and necessity, not institutional facilitation. Still, these mixed engagements became vital loci for gathering insights into European psychiatry reform efforts, documenting internal contradictions, and participating in multi-stakeholder policy dialogues.

In methodological terms, mixed engagement provided both richness and fragmentation. While digital ethnography (Pink et al., 2016) enabled documentation of live decision-making, consensus-building, and conflict management processes across institutional networks, the absence of sustained embodied presence constrained access to informal, unmediated dimensions of field interaction (Knorr-Cetina, 2001). Nonetheless, the hybrid format allowed triangulation of observations across formats and contexts, building a resilient methodological platform. The COST Action structure -requiring collaborative workplans, position papers, and multilateral engagement -also served as a structural frame to implement action-research principles within a semi-institutional format. Through these efforts, the thesis was able to interface with high-level reform initiatives and policy frameworks while remaining grounded in critical medical anthropology and lived experience perspectives (Fricker, 2007; Gill & Donaghue, 2016).

This section follows the standardized methodological reporting structure introduced earlier, documenting each fieldwork strand across the dimensions of identity, method, ethics, and impact. The hybrid modality is neither a compromise nor a flaw -it is a reflection of contemporary conditions, where exclusionary systems force creativity, digital tools become sites of solidarity, and research under oppression adapts to survive. Each of the entries that follow was conducted not in ideal conditions, but under a praxis of persistence, care, and scientific accountability.

2.3.3 - In person fieldwork engagements, scientific mission in Trieste

his ethnographic fieldwork employed a combination of shadowing and key informant interviewing as principal methodological approaches, embedded within the broader framework of medical anthropology and situated ethnographic inquiry. The study was conducted over a continuous one-month period of intensive observation in Trieste, Italy, following a preparatory phase of one month dedicated to local immersion, linguistic familiarization, and initial contact-building with institutional actors. The methodological focus was on capturing the lived practices, institutional cultures, and relational dynamics of a community-based mental health system historically shaped by deinstitutionalization and social psychiatry.

Shadowing, as deployed in this fieldwork, refers to a real-time, mobile ethnographic method involving sustained and systematic accompaniment of mental health professionals in their everyday activities. This approach was selected to access and interpret the concrete implementation of care beyond formal documentation or prescriptive models. The technique allowed for direct observation of clinical routines, interprofessional coordination, user-provider interactions, and spatial configurations of therapeutic activity across multiple settings, including community mental health centers (CSM), residential units, outpatient services, and home-based interventions. The researcher was embedded in the flow of professional routines, actively present during consultations, team meetings, mobile units' rounds, and informal debriefings, without interfering in clinical decision-making processes. The temporal continuity of this mode of inquiry facilitated a processual understanding of care as relationally constructed and dynamically negotiated.

In parallel, semi-structured and informal interviews with key informants were conducted throughout the observational period. These included clinical directors, frontline staff, social workers, peer support figures, and long-term service users. The interview protocol was designed to elicit experiential narratives and professional reflections regarding the operationalization of the Trieste model, with attention to tensions, evolutions, and normative commitments. Interviews were often conducted in-situ, before or after shared activities, and adapted to the temporal and affective rhythms of the field. The combination of structured prompts and open-ended dialogue enabled the documentation of local epistemologies of care, as well as critiques and defensive practices emerging from within the system itself.

The researcher also attended public meetings and community events relevant to the functioning of the mental health services, including a municipality-level discussion involving the mayor and clinical representatives concerning the social response to a patient with behavioral challenges. These public moments were approached as critical ethnographic sites where psychiatric discourse intersects with civic governance, and where relational care is renegotiated in light of broader institutional and social expectations.

Throughout the fieldwork, daily fieldnotes were produced, incorporating descriptive accounts, reflexive commentary, and analytical memos. This iterative process of documentation supported continuous theory-building and allowed for triangulation between observed practice, professional narratives, and institutional discourse. Additionally, the researcher engaged in unstructured observational walks across the urban space, including visits to former asylum grounds and cooperative enterprises, to contextualize the spatial and historical transformations of the mental health infrastructure in Trieste.

Overall, the methodological design of this study emphasized proximity, reflexivity, and methodological pluralism. The use of shadowing and key informant interviewing enabled a layered, embodied understanding of a mental health system in practice, capturing both its normative aspirations and its lived complexities. These methods were instrumental in generating empirical insight into the relational, political, and spatial dimensions of psychiatric care within a post-institutional, community-oriented framework.

Table 58 - In-person fieldwork activity: activity, description, methodological approach

Description	Methodological Approach	Observed or Projected Impact
On-site research at the WHO-recognized community psychiatry model. Full-time presence in mental health centers, residential facilities, and emergency care units.	Immersive observation, participant informal ethnographic interviewing, process tracing, and narrative documentation.	Offered in-depth empirical evidence on non-coercive psychiatric practice, institutional dignity, and the socio-political limits of reform sustainability.

2.4 Conferences, seminars, and symposium-based methods

The use of academic and professional events -conferences, seminars, and symposiums -as a methodological component of this dissertation is grounded in the principles of action-research, epistemic engagement, and emancipatory pedagogy. These spaces offered not only opportunities for knowledge dissemination but also served as arenas for participatory validation, horizontal critique, and exposure of systemic tensions within the psychiatric field. Participation was selective, constrained by structural violence and economic precarity, but maximized for strategic relevance. Most events were attended remotely due to financial restrictions, institutional abandonment, and the obligations of care and survival in an abusive context. When possible, presence was asserted despite the impossibility of preparation under dignified conditions, often immediately following episodes of medical harm, including poisoning and beatings that went unacknowledged or were actively concealed by professionals responsible for safeguarding.

Attending such events thus became both an act of methodological rigor and civil disobedience. The pain of listening to self-proclaimed experts -some defenders of coercive practice, others complicit through silence -was rendered more acute by the contradiction between their privileged discourses and the reality of daily criminal abuse endured by this researcher. This epistemic and affective dissonance marks a core feature of this methodology: the conscious refusal to dissociate scientific observation from ethical accountability. The emotional labor involved in confronting these contradictions was substantial, but not ancillary. It was the method. As feminist and decolonial thinkers have long emphasized, the researcher’s body is both a site of data and a vehicle of resistance (Haraway, 1988; Harding, 1993; Collins, 2000). What is witnessed, endured, and

contested during such events cannot be abstracted from the epistemological process without reproducing the very violence this dissertation aims to expose and undo.

The conferences included in this methodological strategy range from the ISPS international meeting to WPA-sponsored congresses and survivor-led events. Each venue contributed to the articulation of resistance, identification of allies, and gathering of situated knowledge. Dialogues, presentations, and confrontations were documented through reflexive fieldnotes and memos, later analyzed in terms of alignment with international human rights standards and scientific rigor. Not all spaces were safe, and many reproduced the patterns of structural exclusion and symbolic violence characteristic of mainstream psychiatry (Rose & Abi-Rached, 2013; Newnes, 2021). Yet, within them, critical narratives circulated, and the researcher's testimony was not merely tolerated but welcomed in some cases -particularly in survivor-led and ethically attuned contexts. The discrepancy between these spaces speaks volumes about the state of the field and the urgent need for structural reform.

This dissertation therefore treats conference participation not as ancillary dissemination but as a core method: a form of political witnessing, boundary-work, and translational science that links micro-ethnography with macro-structural diagnosis (Gieryn, 1999; Hacking, 1999). It is a laboratory of discourse, where language, silence, posture, and alignment reveal the deeper architectures of professional complicity and emancipation alike. Speaking truth under threat, while recovering from torture, is not an exaggeration of positionality -it is the scientific condition from which this field of inquiry must be reconstituted. These events made visible the paradigm shift underway: from paternalism and clinical supremacy to models of shared decision-making, personhood, and community-based recovery (Topor et al., 2020; von Peter et al., 2019; WHO, 2021). The contrast between those clinging to obsolete dogmas and those charting emancipatory paths is not merely rhetorical; it is the terrain on which future lives will be lost or protected.

The method, then, is exposure -to hostile discourses, ethical bankruptcy, and ongoing harm -but also to solidarity, co-resistance, and cognitive justice. It is in this tension that truth emerges, not as an abstract property, but as a product of struggle, validation, and situated responsibility. As the fieldwork reveals, systemic change does not emerge from passive publication but from embodied articulation, dialogical encounter, and the radical honesty of those whose survival itself is methodological resistance (Fricker, 2007; Tronto, 1993; Moncrieff et al., 2010).

2.5 Teaching as action-research and curriculum co-production

The integration of teaching within this dissertation is not incidental but forms an essential component of its methodological framework. From the standpoint of action-research, teaching is itself a site of inquiry and intervention, where knowledge is not merely transmitted but co-constructed in dialogue with learners, colleagues, and institutional structures (Kemmis et al., 2014). The engagements described here unfolded under precarious conditions -marked by profound institutional betrayal, near-fatal poisoning, and the systematic degradation of the author's physical and professional capacities -Yet, they signified a pivotal recovery and the reclamation of voice, knowledge, and transformative potential. From being unable to speak or write, to guiding mental health education in universities and scientific networks, this pedagogical journey constitutes both an embodied method and a political act of resistance and reconstitution.

Teaching took multiple forms, including guest lecturing, formal curriculum development, participation in pedagogical collectives, and the creation of open-access resources. These activities were both necessity and strategy: necessary for implementing the research's theoretical contributions into practice; strategic for securing a viable professional pathway post-PhD, especially given the systemic marginalization of critical researchers within conventional career structures. Action-research methodology prescribes iterative reflection, situated learning, and systemic feedback loops (Stringer, 2014). Teaching allowed this process to materialize, not as abstraction, but as dialogic transformation. Students became both recipients and co-analysts of emergent knowledge; institutions became testbeds for epistemic reform; classrooms became platforms for validating survivor knowledge, integrating trauma-informed pedagogy, and operationalizing One Health principles in psychiatric education (Davies et al., 2021).

This methodological layer is grounded in a biocultural pedagogy that links molecular neurodevelopment with social determinants, ethical formation, and institutional behavior (Kohrt & Mendenhall, 2015). To teach under these premises required not only scientific rigor, but also radical clarity about the structural violence that shapes both clinical and academic environments. The author's lived experience -of systemic torture, forced silencing, and coercive medicalization -was not hidden in these teaching engagements. It was presented analytically, with evidence, as part of an open learning strategy that dismantles epistemic hierarchies and reconfigures the authority of knowledge from credentials alone to lived epistemologies and co-produced insights (Collins, 2000; Fricker, 2007; Cresswell & Spandler, 2013).

Initial engagement with the American Anthropological Association's Medical Anthropology Health Professional Education interest group laid the groundwork for future licensing pathways for trainers and course participants, enabling the broader dissemination of best practices in open, rights-based education. Parallel participation in the EU AURORA excellence alliance, particularly through the Health Working Group, advanced the integration of shared microcredentialing across member institutions and allies. These efforts converge around a transformative pedagogical vision: to embed health education within the Sustainable Development Goals, One Health frameworks, and citizen science initiatives, ensuring accessibility not only for recognized citizens but for stateless populations and structurally excluded communities. This vision actively informs the development of open-access educational resources, MOOCs, COIL exchanges, and open courseware, licensed to guarantee global reach and long-term sustainability. Teaching is not merely a professional aspiration but an ethical imperative: to serve, as soon as the doctoral defense is completed, as a professor of global mental health and medical anthropology in the full sense, one committed to restoring human sanity, not defined by corrupted norms but by dignity, protection, and care. This trajectory has unfolded in the face of sustained personal and institutional threats, with earlier action-research roles within initiatives such as ICAM, MELISSA, and biocultural medical education in engineering environments cut short by structural violence. The methodological foundation the researcher have built, and continue to refine, is both a survival strategy and a mandate. It affirms the right of all, especially the most stigmatized, to safety, education, and scientific participation. In a world that trains its institutions to abandon, shame, or destroy entire populations, among them, survivors, single mothers, displaced children, and racialized bodies, this work insists on another definition of sanity: one rooted in collective ethics, not institutional corruption.

The 1st International Conference of Aerospace Medicine (ICAM 2022), held in Paris from September 22–24, 2022, alongside the European Space Agency's MELiSSA Conference,

represented not only milestones in space health research but critical junctions for my own academic and professional trajectory. My research group, comprising collaborators from the Aerospace Medical Student and Resident Organization (AMSRO), the Aerospace Medical Association (AsMA), and the Space Generation Advisory Council, had posters and presentations accepted at both events, reflecting our commitment to advancing sustainable, bioculturally aware life-support systems and trauma-informed care models applicable both in space and on Earth. However, due to the escalating violence, psychological torture, and systemic abuses endured during that period, the researcher was forced to withdraw from participation. This loss, both personal and collective, symbolized a deeper rupture: the interruption of some of the most promising trajectories for humanity, at a time when integration of cutting-edge knowledge into health, education, and civic life is not only possible but urgently needed. Space medicine, and initiatives like MELiSSA, offer critical insights into how humans can thrive under extreme conditions, maintain cognitive and emotional balance, and develop resource-efficient systems that protect life. These lessons should be guiding how we educate, organize, and reform our societies. Tragically, the very technological and scientific gains meant to support human flourishing are too often weaponized or misused, while those most engaged in their ethical advancement are silenced or harmed. Despite this, the vision continues through actions like EU BEACON: initially born from the aspiration to translate aerospace and planetary health breakthroughs into equitable systems of care, the action now focuses on education in One Health for schoolchildren, supported by new digital and open-source technologies. This work is building a new way of learning, planning, and caring, globally interconnected, ethically grounded, and oriented toward peace, not conflict. Toward lives that are long, dignified, and meaningful, not lives spent enduring suffering that could and should have been prevented. We persist, not out of utopian idealism, but from a grounded understanding of what is both necessary and scientifically feasible.

This approach aligns with the ethics of Open Science and public mental health: all materials produced have been and are designed for dissemination beyond the classroom, through the open knowledge base of EU BEACON and its dissemination platforms, which the author coordinates, as well as other platform and its own open science notebook. With over 20,000 subscribers and readers, the dissemination role is not merely administrative but epistemological: it affirms that education, communication, and structural reform must be unified processes, conducted in public, accountable to the most harmed, and grounded in science that serves dignity, survival, and transformation (Nowotny et al., 2001; WHO, 2021). In this role, the researcher developed pedagogical content on neurodevelopment, social determinants, and ethical psychiatry for undergraduate and graduate levels, while supporting curriculum transformation at partner institutions. Teaching thus enabled and enables the research to become action as well, the theory to be tested through interaction, and the methods to be replicated and refined in real time. It marked the transition from wounded subject to critical professor-in-training, reclaiming public space and professional legitimacy through the very act of education. As Freire (1970) posited, education is never neutral: it either reinforces oppression or facilitates liberation. This dissertation embodies the latter, using teaching as method, platform, and strategy to ensure that those who have been broken by the system may one day lead it toward justice.

2.6 Policy engagement, public scientific contribution to institutional change

In an act that is indistinguishable from political persecution in authoritarian regimes, the police in Sweden treated the hosting of a scientific symposium -featuring internationally recognized experts exposing torture, extrajudicial psychiatry, and forced organ extraction -as a potentially criminal activity. Rather than safeguarding academic freedom, the Swedish authorities' response mimicked the logic of the People's Republic of China: classifying critical research and human rights reporting as subversion. The implications of this alignment go far beyond personal retaliation -they mark the dangerous transnational enforcement of authoritarian epistemologies by democratic institutions (Fricker, 2007; Scheinin, 2022). That the legal apparatus in an EU member state could distort the law to this extent -defining scientific inquiry as deviance, undermining whistleblowers, and sustaining networks of family-based, institutional, and state-level abuse, ignoring all reports, and protecting the abusers instead while destroying a career, a family, exposing children to further harm under alleged protection, shielding the criminals and disallowing other forces and professional services to even check their well-being -amounts not simply to malpractice, but to a systematic betrayal of democratic principles. These actions, and the prolonged refusal to rectify them, constitute an institutional pattern of epistemic and political violence against the very individuals upholding the values and responsibilities that define civic life and professional duty (Méndez, 2013; Nowak, 2019; UN OHCHR, 2020).

What has unfolded since that turning point is a continuum of domestic and public destruction. The complicity of law enforcement and social services -acting in lockstep with family abusers, silencing dissent, denying protection -demonstrates how informal networks of repression thrive when formal oversight collapses. This failure is not merely a bureaucratic oversight, nor can it be excused by fear or capacity constraints. These actors have acted with clarity and determination to destroy the lives of those who speak truth under duress. Their actions -backed by institutional cowardice or opportunism -have destroyed families, separated children, and erased professional careers. They have protected the guilty and punished the witnesses, all while enabling foreign logics of repression to corrupt our internal norms. In doing so, they have abandoned the very mandate that grants them legitimacy: to uphold law, protect human rights, and ensure the integrity of public service (Flynn et al., 2021; Gill & Donaghue, 2016; PEN International, 2021).

The urgency of our work cannot be overstated. Millions of lives are at stake -not metaphorically, but literally -when institutional truth-tellers, health defenders, and scientists are systematically discredited, silenced, or killed. The betrayal of democracy by democratic institutions, the alignment of legal systems with regimes of violence, and the distortion of science into compliance are now global syndemics requiring coordinated resistance. The murders of scientists, journalists, and professionals for doing their work -legally and ethically -is not a statistical anomaly; it is the emergent pattern of a global decay (Chomsky, 2017; Singer et al., 2020). Against this tide, we are building a global network -thousands strong and growing -through the EU BEACON action and its international allies. One Health is not a slogan. It is an existential necessity. No state, failed or functional, can afford to ignore it. In fact, it is often the rogue states -where citizens suffer the most -that require our science, care, and solidarity the most. Our collective duty now is to ensure that justice, education, and scientific truth are never again treated as threats, but as the most urgent forms of defense we have left.

2.7 Open methods, knowledge bases, justice, dissemination, engagement and exploitation

The integrity of scientific inquiry, particularly in the domains of psychiatry, public health, and medical anthropology, requires a steadfast commitment to open science principles. In the present doctoral project, open methods were not a peripheral addition, but a structural axis through which epistemic justice, democratic accountability, and knowledge sustainability were pursued under the harshest conditions of violence, precarity, and systemic abandonment. From the earliest stages of this research, transparency in methodology and dissemination served as not only a scientific standard, but an ethical imperative. Open access fieldwork notebooks, collaborative platforms, and public engagement infrastructures were deployed to invite collective scrutiny, foster distributed ownership, and safeguard the reality of the harms reported -precisely when institutional denial and epistemic injustice were the norm, not the exception (Fricker, 2007; Elliot et al., 2017; Tennant et al., 2019).

In parallel, this approach confronted violent opposition. The very act of reporting -through calls for participation, open posting of methods and observations, and peer engagement -was met with coercion and intimidation. The abusers, some with institutional protection and others embedded in kinship systems or state-supported networks, repeatedly demanded the removal of posts and threatened retaliation, both directly and through legal proxies. At the height of threats against the life and safety of the researcher's children and beloved ones, the demand was not for dialogue, but for erasure. The silencing of evidence, a core mechanism of authoritarian governance and institutional cowardice, reemerged in academic and civic spaces where transparency and protection should have prevailed. These are not isolated events but part of a broader pattern in which survivor-led research and action-based inquiry are undermined by weak ethical enforcement, professional betrayal, and moral complicity from peers who choose comfort over courage (Medvecky & Leach, 2017; Cummings, 2020).

Rather than receive support from colleagues within institutions allegedly committed to scientific progress and human rights, many fled or disengaged at the first sign of controversy. Some played roles as performative allies, interested in the optics of solidarity without accepting the responsibilities it entails. Others simply turned away, invoking professionalism or neutrality while refusing even to verify facts or stand by foundational principles of care, dignity, and truth. This cowardice -amplified by the prestige economy and peer review systems hostile to dissent -exposes an institutionalized culture of avoidance and passivity that enables abuse through omission. It is not a matter of moral weakness alone, but of structural immaturity, in which people ascend to positions of influence without the requisite ethical formation, resilience, or historical understanding to exercise those roles meaningfully (Milan & Treré, 2019; Gill & Donaghue, 2016).

Such dynamics mirror the larger failure of global political systems, where state-backed actors, rogue regimes, and organized crime syndicates exploit opacity, fear, and disinformation to enforce silence and control. Science, journalism, and civic reporting are increasingly targeted as subversive acts -rendered punishable by administrative sanctions, institutional retaliation, or direct threats to life. The consequences of such normalization are catastrophic. They corrode the pillars of democratic society, escalate ecocide, genocide, and sociopolitical collapse, and leave the global community paralyzed in the face of accelerating thresholds in climate, health, and social cohesion (IPBES, 2019; Horton et al., 2014; Amnesty International, 2021). In such a context, open science is not merely a scholarly ideal -it is a defensive infrastructure for survival. The ability to document, share, verify, and act upon knowledge is what allows reality to be negotiated collectively, and for

the truth to be protected from weaponized lies and denial (Fecher & Friesike, 2014; Bezuidenhout et al., 2017).

The present thesis, therefore, frames dissemination and exploitation not as academic requirements, but as existential imperatives. The maintenance of open digital infrastructures -despite financial ruin, institutional non-support, and active obstruction -represents a commitment to a future where research does not disappear under duress, where science is not the exclusive domain of the powerful, and where the most affected are not once more erased. Calls for participation were posted openly; methods were documented in real time; feedback was invited, and networks were built from below, drawing on the shared suffering and determination of those long excluded from the academic and clinical mainstream. This form of reporting honors the sacrifices made by the researcher and their collaborators, by colleagues who risked their own standing to support, and by the many whose lives were prematurely lost due to the systems this work seeks to transform (de Sousa Santos, 2018; Campbell & Burgess, 2012).

In conclusion, this dissertation reaffirms that open science is not neutral. It is political, ethical, and structural. It calls for a world where institutional cowardice, professional betrayal, and authoritarian suppression cannot so easily prevail. Where reporting is protected, where transparency is enforced, where scientific truth serves as a force for justice. And where the refusal to speak up, to act, or to defend the abused is not only called out, but held accountable -as we move toward a system that values life, dignity, and the future of all.

Across the documented fieldwork and interdisciplinary analysis of this dissertation, a deeply rooted pattern emerges in how legal and health systems not only fail to respond to individuals in states of distress or medical crisis but actively convert these moments into long-term vulnerabilities. Methodologically, the system is built on an inversion of the therapeutic principle: instead of moving individuals from illness to health, it transforms temporary suffering or institutional betrayal into chronic pathology, in need of control, isolation, or degradation (Rose, 2006; Foucault, 1973). This is not merely a failure of service delivery, but an inherited epistemology and operational code drawn from eugenic, carceral, and colonial precedents (Gori & Beneduce, 2017; Sisti et al., 2015).

In modern psychiatric and legal systems, particularly in Western democracies claiming to uphold human rights, methods of care are misused as tools of subjugation. Individuals labeled as mentally ill -especially those whose suffering is connected to abuse, violence, or systemic injustice -are not offered empowerment or restoration. Instead, they are subjected to surveillance, over-medication, isolation, or structural abandonment. The system treats their condition not as a legitimate human response to trauma but as a defect in need of containment. The medical file becomes the new scarlet letter: branding the individual with chronicity, unreliability, and professional exclusion (Metzl, 2010; Fricker, 2007).

The counter-methodologies deployed by these institutions are often disguised as safeguards -diagnostic tools, risk assessments, treatment guidelines -but serve to recode vulnerability as disorder, dissent as pathology, and structural failure as personal dysfunction. As in historical eugenics, the root assumption is the unfitness of the subject: no longer marked for sterilization or asylum, but now for permanent social disqualification through algorithmic profiling, pseudoscientific risk modeling, or legal guardianship structures that deny the capacity for self-determination (Wang & Fawcett, 2023; Council of Europe, 2023).

This is where the One Health Education methodology must intervene -not as a metaphor or institutional label, but as a realignment of the core pedagogical and clinical principles guiding our public systems. One Health, in its true biocultural and structural application, rejects the artificial split between human suffering and ecological, educational, economic, and systemic wellbeing (Zinsstag et al., 2021). It insists that when the most abused, beaten, and silenced are left unprotected -when their scars are medicalized instead of repaired -then it is not only the individual who is poisoned, but the very well from which society draws its legitimacy, labor, future.

Educational systems must teach, from the root, that vulnerability is a social responsibility, not a personal failing. Systems must be structured to recover, document, and repair what violence has torn apart -not to erase and render indistinct through bureaucratic language and denial. This dissertation proposes the One Health method not merely as content to teach, but as the form of teaching itself: radically inclusive, trauma-informed, structurally grounded, and ethically absolute. A system that fails to protect, that targets whistleblowers, that renders illness permanent through its negligence or intentional sabotage, is not flawed -it is functioning precisely as designed under a regime of denial and systemic reproduction of inequality (Campbell & Burgess, 2012; WHO, 2021; Horton et al., 2014). Let us name the system not as malfunctioning, but as a methodologically consistent apparatus of silencing, historically traceable and legally unjustifiable. Let us recognize that the task of the researcher is not to adapt to this structure, but to overturn it with rigorous science, full transparency, and moral clarity.

Table 59 - Institutional counter-methods masked as care

Systemic action	Method employed	Masked justification	Real function	Structural consequence
Medicalization of trauma	Diagnostic labeling without trauma history inclusion	Alleged evidence-based classification	Deflection from institutional abuse	Chronic invalidation and social exclusion
Destruction or withholding of records	Blocking or erasing access to medical, legal, or academic files	Alleged privacy, alleged security, or alleged clinical discretion	Disempowerment and epistemic erasure	Denial of redress, legal defense, and scientific reporting
Algorithmic profiling and flagging	Predictive policing, alleged risk assessment, or psychiatric flags in systems	Alleged preventive care	Control of population labeled as dangerous	Entrenchment of racialized, class-based, or gendered violence
Coercive or involuntary treatment	Forced drugging, institutionalization, guardianship	Alleged lack of insight, alleged duty of care	Enforcement of state power over bodily autonomy	Legalized torture and destruction of agency
Denial of witness and whistleblower protection	Non-investigation of abuses, reclassification as delusional	Alleged unsubstantiated, alleged lacking credibility	Protection of corrupt institutions	Continuation of abuse and silence
Narrative inversion	Pathologizing those who document, speak, or resist	Alleged grandiosity, alleged paranoia, alleged mental instability	Discrediting survivor-researchers and critics	Suppression of dissent and systemic rot
Delegitimization of one health knowledge	Blocking education, mislabeling bioecological content	Alleged not clinical, alleged not primary care	Protecting industrial interests and institutional inertia	Collapse of integrative health capacity

Systemic action	Method employed	Masked justification	Real function	Structural consequence
	as fringe			

The foundational need for open-source infrastructures, transparent data governance, and radical accountability in mental health and society-wide science must be understood as a civilizational imperative. Open methodologies, published protocols, verifiable processes, and version-controlled documentation are not optional add-ons but structural safeguards essential to the preservation of collective sanity, public trust, and democratic functionality. In a domain as sensitive and high-stakes as mental health -where misclassification, diagnostic violence, and institutional malpractice can destroy lives -the requirement to open data for rigorous public scrutiny must be treated as a categorical ethical standard, not a discretionary practice. Scientific inquiry thrives under conditions of falsifiability, replication, and systemic transparency; mental health research, in particular, must expose not only its findings but also its errors, contexts, and power asymmetries (Ioannidis, 2005; Nosek et al., 2015; Munafò et al., 2017).

A thriving and economically sustainable knowledge society depends on feedback loops of continuous improvement -on honest reporting of failure as a key pedagogical resource and the prevention of epistemic stagnation through mechanisms of accountability. Honest mistakes, when openly addressed, become the raw material of institutional learning and collective competence. Conversely, misallocation of responsibility, institutional misallocated shame and crimes hidden, and the cultural coding of new errors, acting and learning responsibly, as personal shameful acts to punish, convert those failures into crimes of omission repeating over and over, fueling a corrosive cycle of systemic collapse and social despair (Fricker, 2007; Edwards & Roy, 2017). This calls for the universal adoption of open science platforms in psychiatry, medicine, education, and public service administration, ensuring that decisions affecting human lives are not buried in opaque silos but co-governed by informed, ethically grounded, and scientifically trained citizens. The educational system must rise to meet this demand, equipping each new generation not only with scientific literacy but with civic character, trained in the responsibility to build and uphold truth-based institutions and ethical governance infrastructures (Kennedy, 1963; European Commission, 2016; UNESCO, 2021). The future is not secure in the hands of those who play at adulthood while weaponizing authority against vulnerability. It must be held by those who understand that power entails duty -always public, accountable, and protective of life, not its degradation.

In operationalizing the civilizational imperative for open infrastructures and truth-based governance, this doctoral work adopted a situated action-research methodology that actively resisted opacity, disinformation, and diagnostic authoritarianism in the fields of mental health and institutional science. The core methods implemented were not theoretical aspirations but practical necessities developed and executed under duress, in conditions marked by extreme precarity, targeted violence, and systematic betrayal. These methods include open publication of protocols, continuous digital documentation (despite recurrent sabotage), version-controlled knowledge bases, and full public accountability across all phases of research, coordination, and dissemination.

Scientific documentation was treated as a form of civil protection -an epistemic archive meant to resist the erasure of facts, the rewriting of institutional records, and the gaslighting of survivor-researchers by abusive systems. The collapse of scientific and legal safeguards was not an abstract concept but a lived experience. Mental health classifications were weaponized to obscure physical

abuse, police refused to take testimony despite visible injury, and support services stood with the perpetrators, enabling a long continuum of harm. Against this, the methods of this thesis included: maintaining a personal and collective knowledge base with open-source tools; preserving digital remnants despite systemic sabotage of data (loss of cloud accounts, email histories, and collaborative platforms); and engaging directly with affected communities in co-producing curricula, protocols, and research agendas responsive to lived reality.

Importantly, this was not an individualized intellectual project. It emerged from collective experience and sought to articulate collective need. The methods were co-informative, born from dialogue with other survivors, clinicians, and global researchers facing similar patterns of erasure and structural silencing. Their suffering, and the systemic suppression of their voices, reinforced the need for structural open science -science that is not a private enterprise of experts, but a public infrastructure of shared survival (Fricker, 2007; Munafò et al., 2017). Data governance, in this context, had to mean more than GDPR compliance: it required safeguarding the narrative and cognitive integrity of individuals forcibly rewritten by the state, by institutions, and by professional complicity. Version control of clinical and legal documentation was approached not only as a technical standard but as an ethical obligation -one that, if ignored, enables gaslighting, retraumatization, and structural repetition of abuse (Ioannidis, 2005; Edwards & Roy, 2017).

Working in these conditions -after being poisoned, repeatedly beaten, and punished for fulfilling basic parental responsibilities -meant that action-research itself had to become a survival practice. The state's refusal to protect, its complicity in abuse, and its administrative weaponization of mental health labels made scientific rigor an act of dissent. Every effort to teach, write, organize, and document was criminalized or blocked. Still, the action-research proceeded: calls for participation were issued; materials and protocols shared in the open; courseware developed in real-time with the communities it was meant to serve. Civic and scientific communication was upheld as a principle of life-preservation, not just career development.

The methods described were constrained by the near-total lack of funding, equipment, and institutional support. Despite these constraints, this research initiated the development of EU BEACON's governance protocols for open science in education and health. It created free-access survey instruments, digital training materials, and a platform to disseminate evidence on coercion and structural violence, serving more than 20,000 users and stakeholders globally. The very process of carrying out these methods was pedagogical in nature -training others in critical literacy, non-coercive practice, and systems thinking, while resisting the systemic gaslighting so typical of psychiatric and social services under crisis capitalism (Fisher, 2009; Campbell & Burgess, 2012).

To document honestly, in public, in real time, from within states and systems whose own agents violated the rights of children, researchers, and citizens, was not a theoretical choice. It was what had to be done. These methods, learned through suffering, have global relevance. They form the backbone of a One Health education and research infrastructure that understands science not as control, but as a collective obligation to sustain truth, prevent harm, and heal what can still be saved.

To protect and amplify the scientific effort described, this work concludes with a methodological pivot: from survivor-led field documentation and open resistance to diagnostic coercion, toward the institutionalization of protective infrastructures through expert systems. The EU BEACON One Health Education Action, founded and guided by this research, serves as a living framework for

implementing algorithmically transparent, ethically grounded, and participatory expert systems for mental health, education, and public governance. These systems -under development and iteratively tested -embody open science principles not merely as aspirational goals but as operational requirements, designed to counter the degradation of knowledge and the manipulation of diagnostics by state and professional actors in positions of abusive power.

Scientific rigour, in this context, must expose and dismantle the pathologies of power that allow institutional actors to feign victimhood while perpetuating abuse. It is methodologically urgent to name this inversion of responsibility: the professionalized perpetrator class that frames accountability as persecution, that feigns outrage and appeals for 'help' to evade scrutiny. This psychological masquerade, enabled by bureaucratic privilege and enforced silence, is not an isolated phenomenon but an institutionalized practice deeply embedded in clinical, legal, and educational systems across Europe and beyond (Herman, 1992; Foucault, 1977; Rose, 1998). It functions by coopting the language of suffering while dehumanizing those truly harmed, turning vulnerability into criminalized deviance and criminality into an administrative routine (Goffman, 1961; Scott, 1990).

The scientific method, properly implemented, offers a counter-method: evidence, transparency, reproducibility, and epistemic accountability. But in psychiatry and state-aligned disciplines, the failure to integrate biology as a living, dynamic process -not merely as reductionist neurotransmitter charts but in its evolutionary, ecological, and developmental reality -has fostered a grotesque simulacrum of science. That simulacrum upholds the most violent forms of institutional control while claiming biological legitimacy. Yet, it lacks molecular fidelity, ignores physiological systems integration, and remains ignorant of basic zoological, comparative, and developmental biology -thus betraying its foundational claims. Open science is the only valid corrective: a continuous, distributed, peer-auditable model of institutional learning, rooted in the democratic governance of knowledge and implemented from the ground up across research centres, clinical settings, educational hubs, and the wider citizenry (Ioannidis, 2005; Munafò et al., 2017; UNESCO, 2021).

This research shows how necessary to acknowledge a mode of fieldwork and scientific perseverance that no academic training prepares for, Yet, which constitutes a core methodological contribution of this dissertation: the forced displacement and transnational survival under extreme risk, with a backpack as the only equipment, and every departure executed before dawn under the imminent fear of death. The flight from institutional and domestic persecution was not symbolic -it was physical, procedural, and existential. It entailed months of sleeping dressed, boots on, ready to escape at any moment, knowing the children had already been taken, mourning in silence while strategizing survival. This form of autoethnographic resistance is not outside the domain of scientific method; rather, it represents a radical intensification of it, where documentation, memory, and responsibility toward others become the only remaining tools of epistemic agency (Behar, 1996; Fassin, 2017; Scheper-Hughes, 1995). The betrayal by those charged with protection -national police, social services, courts, university structures -was not an incidental oversight but a deliberate and sustained collapse of democratic duty, often acting in coordination with foreign logics of control, in contradiction to European and international human rights law (Nowak, 2019; UN OHCHR, 2020; Scheinin, 2022).

In such conditions, method becomes indistinguishable from life itself. The careful maintenance of a secure digital knowledge base, the decision of what documents to carry and what to sacrifice, the

continuation of writing and coordination amidst flight and grief -these were not journalistic instincts, but scientific obligations performed under torture-adjacent constraints (Méndez, 2013). The work was not only about preserving data, but preserving the possibility of speaking truth. It is thus necessary to state, without embellishment or apology, that all findings in this dissertation - conceptual, empirical, political -were extracted against a backdrop of structural hatred, criminal impunity, and a coordinated attempt to silence a witness to systemic psychiatric violence. The institutions involved, both public and professional, operated with such bold disregard for life, legality, and scientific integrity that their conduct will require independent, transnational investigation. In the meantime, this work proceeds as it began: by recording, analyzing, and resisting, not in safety, but in clarity. One Health requires the protection of those who produce and safeguard the epistemic structures we depend on to survive pandemics, prevent atrocities, and dismantle corruption from within. If this work survives, it is because violence did not win -yet. But its agents remain in position, and they remain dangerous.

2.8 Contextual introduction to published paper: ethical imperatives in qualitative research

The following paper, accepted for publication in the *Methods in Psychology* Special Issue on "Ethical Issues in Qualitative Research" (Elsevier, Q1), represents a culmination of five years of longitudinal, multisite fieldwork carried out in Spain, Sweden, Italy, and Indonesia under the auspices of three major EU COST Actions (FOSTREN, ReMO, and BEACON). It directly addresses the central thematic core of this special call, which sought to explore ethical dilemmas in qualitative research, particularly in high-risk, structurally violent or epistemically contested environments. The inclusion of this peer-reviewed paper at the close of the chapter aligns with the thesis's overarching methodological and bioethical orientation. It exemplifies how medical anthropological inquiry must engage not only with procedural ethics, but with dynamic, real-time ethical responsiveness in contexts of institutional betrayal, psychiatric coercion, and testimonial silencing (Fricker, 2007; Guillemin & Gillam, 2004). The study contributes substantively to current debates around the necessity of trauma-informed, open science-based, and action-research grounded methodologies, in alignment with recent WHO, UN, and Council of Europe calls to reform coercive mental health systems (World Health Organization, 2021; Pūras, 2020; Council of Europe, 2023).

As a contribution to this high-impact special issue, the paper strengthens the thesis's evidentiary base and exemplifies the translational potential of field-based qualitative research to inform both policy and scholarly discourse. It operationalizes the methodological and ethical principles elaborated throughout this dissertation -especially concerning epistemic justice, researcher safety, and ethical infrastructures of witnessing -and demonstrates their viability within the peer-reviewed academic landscape. The article thus serves not merely as a product of field engagement, but as a vehicle for institutional critique and scholarly transformation.

Chapter 3: Results and findings on shared decision-making and autonomy

Summary: This chapter presents the collected body of experiential knowledge gathered through three distinct surveys, each offering critical insights into the lived effects of psychiatric practice and the possibilities for ethical transformation. Rather than reducing responses to aggregate data, the surveys foreground personal testimony, relational complexity, and institutional critique from the standpoint of those directly involved. Across roles and contexts, respondents describe systems that often operate in contradiction to their stated principles: labels that harm rather than guide, interventions applied without consent or reflection, and institutional routines that override dialogue, continuity, and care. Yet, within these accounts emerge clear patterns of awareness and resistance. Many professionals, particularly those with decades of experience, report acting ethically despite systemic constraints, advocating for relational practices and exposing the costs of rigid diagnostic thinking and medication-centered paradigms. Experiences of marginalization, misdiagnosis, and silence recur across responses, but so do concrete efforts to build trust, protect autonomy, and implement dialogical approaches even without formal support. In the first survey alone, over 300 individuals, primarily survivors and relatives, shared their experiences around psychiatric labeling, with striking consistency in reporting harm, coercion, and diagnostic violence masked as treatment. Their accounts form a densely layered indictment of systemic practices that deny context, erase agency, and substitute protocol for presence. From these narratives, it becomes evident that the psychiatric system is not monolithic: its failings are widely known by those within it, and its transformation is already being quietly pursued by those who refuse to normalize harm. This chapter does not claim representativeness, but it does offer rare access to professional, survivor, and family perspectives often excluded from policy discourse. Their convergence points toward urgent systemic changes that are both realistic and necessary, if institutions are willing to listen.

3.1 Introduction

3.1 Introduction to survey based results

The present chapter begins with a corpus of surveys that operate not as statistical instruments, but as distributed ethical mechanisms to capture and amplify situated knowledge within psychiatry. Designed with an intentionally open, reflective architecture, the surveys collected here reject the premise of objectivity through abstraction. Instead, they affirm that meaningful insight arises from the intersection of direct experience, professional engagement, and structural position. Each respondent, whether a clinician, researcher, relative, or survivor, contributes not data points, but testimony. These responses are not to be interpreted as representative in a numerical sense, but as collectively diagnostic of systemic conditions otherwise ignored or normalized.

The function of this block is not to test hypotheses through formal generalization, but to foreground the epistemic validity of lived experience, to map patterns of harm and ethical dissent, and to gather practical knowledge from those who operate inside, alongside, or in tension with psychiatric institutions. The surveys thus serve as participatory acts of witnessing. They were distributed with minimal constraint, favoring narrative prompts, long-form reflections, and context-specific inquiries over fixed-response structures. Their internal consistency arises from this methodological coherence: to restore dignity to the voices long made marginal, and to expose, through repetition, nuance, and contradiction, the systemic mechanisms by which autonomy is denied, violence is institutionalized, and care becomes conditional on submission.

What follows is not a presentation of frequencies or statistical correlations, but a structured analysis of thematic convergence. Across the three surveys, certain patterns are undeniable: coercion masquerading as care; medication regimes enforced without sufficient cause or review; diagnoses imposed without adequate assessment or informed consent; dialogical practices marginalized despite evidence of their effectiveness; and practitioners navigating deep ethical conflicts without institutional support. Yet, these same narratives also reveal points of resistance: professionals quietly adapting practice, users reclaiming meaning, and families demanding recognition. In making space for this knowledge, the survey block fulfills its purpose, not as measurement, but as interruption, confrontation, and reconfiguration of what counts as evidence in psychiatric reform.

3.1.1 Schizophrenia: a study on psychiatric labels and their consequences

This section analyzes the survey titled "Schizophrenia: a study on psychiatric labels," initially deployed to gather qualitative data on the experience and effects of receiving, or witnessing others receive, this specific diagnosis. The results present an overwhelming pattern of social abandonment, medical harm, iatrogenic trauma, and institutional complicity. Respondents included professionals, family members, and diagnosed individuals who offered unfiltered accounts of coercion, suffering, and often irreversible life damage. What emerges is a layered diagnosis of the diagnostic act itself: a medical labeling that produces marginalization rather than care. The responses not only describe harm but also articulate collective insight into the mechanisms of structural violence, evidencing the need for deep legal, ethical, and epistemic reconsideration.

Purpose: This survey aimed to investigate how the diagnostic labels "schizophrenia" and "psychosis" are experienced, applied, understood, and contested across multiple roles, by users, relatives, and mental health professionals. Its primary goal was to unpack the ethical, social, and clinical implications of labeling practices in psychiatry, with special attention to their effects on identity, relationships, institutional processes, and access to justice and care. The survey combined structured quantitative items with open-ended qualitative responses to enable a textured and participatory account of diagnostic power and its lived consequences.

Connection to thesis: This survey is foundational to the thesis's core argument that any ethical system of care must prioritize shared decision-making, autonomy, and structural support over institutional inertia, professional control, or epistemic violence. It exposes how the labeling process, far from being neutral, can damage trust, obstruct care, and obscure lived experiences behind abstract classifications. The findings reveal that many respondents, particularly those with lived experience and reflective professionals, associate these labels not with healing or understanding, but with loss of agency, trauma, and long-term harm. Across the data, powerful critiques emerge about the misuse of diagnosis as a tool of control rather than collaboration, with significant concern for the way these labels are used to bypass personal narratives, silence alternative interpretations, and justify coercive measures. Racial and ethnic bias, overpathologization, and the perception of dangerousness are reported as frequent outcomes, further isolating individuals and reinforcing stigma. Many also reflect on the failure of services to offer trauma-informed, contextualized care that respects personal meaning-making and biographical complexity. The survey also captures the tension between professional communication needs and ethical constraints. While some clinicians defend diagnostic shorthand as useful, most agree that any benefit is undermined when such language becomes totalizing or is used outside of collaborative frameworks. Many call for reform,

adopting narrative formulations, shared interpretations, and the Power-Threat-Meaning Framework, among others, to replace static diagnoses with person-centered understandings.

This evidence supports the thesis's broader commitment to psychiatric reform rooted in dignity, mutual recognition, and cultural transformation. The responses challenge professional normalization of outdated practices and illuminate viable, already-practiced alternatives grounded in collaboration and care ethics. They confirm the urgency of rejecting pathologizing language and call for multidisciplinary retraining, community support, and dialogical practices as conditions for any legitimate mental health system in the 21st century.

Respondent demographics and roles: The survey gathered responses from a total of 356 individuals who occupy a diverse array of roles in relation to psychiatric diagnoses, particularly concerning "schizophrenia" and "psychosis." Of these, 21% were individuals who had personally received such diagnoses, while 10% had received a different psychiatric diagnosis. A substantial proportion, 24%, identified as family members or close friends of someone diagnosed. Most notably, 36% of respondents were mental health professionals, including psychiatrists, psychologists, social workers, and general practitioners. The remaining respondents included students, advocates, caregivers, and individuals engaged with the mental health system in other capacities. This distribution ensures a broad experiential base from which to understand diagnostic impact, relational dynamics, and systemic failure. The range of participants underscores that psychiatric labeling is not a marginal issue but one that touches lives across personal, familial, and institutional domains. The depth of their testimonies confirms the necessity of reform rooted in recognition, co-responsibility, and dignity.

Table 60 - Respondent roles and demographic breakdown

Role/Relationship to Diagnosis	Count	Percentage
Has received a diagnosis related to "schizophrenia" or "psychosis"	75	21.07%
Has received another psychiatric diagnosis	35	9.83%
Has a family member or friend diagnosed with "schizophrenia" or "psychosis"	86	24.16%
Is a mental health professional (psychiatrist, psychologist, nurse, social worker, etc.)	128	35.96%
Not any of the above, but interested in mental health	11	3.09%
Other (students, professionals outside psychiatry, affected parents, advocacy roles, etc.)	22	6.18%
Responses not completed or excluded	34	9.55%

Across the wide spectrum of responses collected, several powerful and recurring themes emerged that speak directly to the epistemic, structural, and interpersonal consequences of psychiatric labeling, particularly concerning "schizophrenia" and "psychosis." These labels were overwhelmingly described not as neutral tools of care, but as symbols of stigma, marginalization, and institutional power. One of the most salient patterns was the perception that these diagnoses often fail to represent the individual's experience, instead functioning as reductive markers that obscure biography, context, and relational meaning. As one respondent put it: *"What the researcher lived through wasn't an illness, it was loss, grief, fear. But they just called it schizophrenia and ignored everything else."* This narrative of reduction was closely linked to another major theme: iatrogenic harm through diagnosis. Many respondents, including professionals, described how

receiving or applying such labels can initiate a cascade of loss: trust, employment, relational support, and even self-worth. Several users described the label itself as more devastating than the experiences that led to their crisis. This idea was powerfully echoed in statements like: *"The diagnosis destroyed my life more than the psychosis ever did."*

Distrust in psychiatric services was another widespread concern. Respondents cited routine diagnostic processes as opaque, non-consensual, and imposed. Family members, too, often reported being excluded from understanding or participating in care decisions. Professionals shared their own discomfort with the rigidity and social impact of these labels, noting that the system frequently pressures them to use diagnoses that do not match the nuanced reality of their clients' lives. One psychologist remarked: *"I use these terms in reports because the researcher have to, not because they help the person in front of me."* A significant number of respondents also highlighted structural bias and racialization, affirming that race, ethnicity, and social class frequently influence how diagnoses are distributed and interpreted. The perception of dangerousness attached to the "schizophrenia" label was seen as a persistent driver of exclusion and coercion, particularly among men, migrants, and racialized individuals. These social dynamics are not anecdotal but form a pattern that reinforces the thesis's core claim that psychiatric systems often reproduce, rather than correct, social injustice.

Despite the prevalence of these critiques, respondents also offered constructive alternatives, many aligned with dialogical and trauma-informed care. Suggestions included abandoning the terms entirely, adopting narrative formulations, or using frameworks like the Power Threat Meaning Framework. These proposals did not come from a place of rejection but from a desire to rebuild care around trust, dignity, and mutual understanding. As one professional respondent wrote: *"We don't need to call people schizophrenic to help them. We need to listen."* These patterns confirm that resistance to diagnostic violence is not confined to activists or survivors but is widespread among those working within the system. The convergence of voices across positions and contexts offers a coherent, evidence-based argument for structural transformation, a shift away from fixed labels and toward ethical, context-aware, and autonomy-respecting models of care.

Table 61 - Recurring themes and key findings

Theme	Key Finding	Illustrative Quote
Diagnostic labels as identity erasure	Diagnoses are seen as reductive, failing to reflect personal experience.	"They didn't ask what happened to me, just what was wrong."
Iatrogenic harm from labeling	Being labeled "schizophrenic" often causes more suffering than the crisis itself.	"The label did more damage than the breakdown."
Loss of trust in professionals	Labels break trust and hinder open communication.	"After the diagnosis, they stopped listening altogether."
Institutional coercion and silencing	Diagnostic practices are imposed, not negotiated.	"I was never asked if the researcher agreed, they just wrote it down."
Fear and stigma in social perception	Public and professional discourse associate diagnosis with dangerousness.	"People avoid you once they hear the word 'schizophrenia.'"
Ethnic and class bias in diagnosis	Minorities and migrants report over-diagnosis and misinterpretation.	"I was treated as violent before the researcher even spoke."
Resistance from within the system	Many professionals express discomfort with labels and seek new approaches.	"I use the term for the system, not for the person."
Desire for narrative and contextual care	Respondents prefer explanatory models that include trauma, biography, and meaning.	"Call it grief, call it trauma, but not a disease."

Theme	Key Finding	Illustrative Quote
Suggestions for reform	Proposals include dialogical practice, shared narratives, and better training.	"We need to learn how to listen before we diagnose."

The findings of this survey reveal a psychiatric system still deeply marked by asymmetrical power, structural neglect, and normative violence, where diagnostic categories like schizophrenia and psychosis often operate not as tools of support, but as instruments of erasure, control, and social exclusion. The most structurally relevant patterns, such as widespread mistrust toward professionals following diagnosis, the depersonalizing effect of labels, the racialization of diagnostic practices, and the reported silence around trauma, reflect a pervasive epistemic injustice, in which those most affected by mental health interventions are also those least heard, least protected, and least empowered to define their own experience.

Beyond interpersonal encounters, the use of fixed psychiatric labels emerges as a systemic mechanism of overreach, legitimizing coercion and silencing through clinical authority, while absolving services of the responsibility to contextualize distress, address social determinants, or offer genuine alternatives to biomedical narratives. These insights support the core thesis that true care requires the redistribution of epistemic power, the centering of first-person knowledge, and the systematic revision of training, protocols, and evaluative frameworks within mental health care.

And yet, the survey also uncovers signs of transformation already in motion. A considerable number of professionals, particularly those with years of reflective practice, are already distancing themselves from rigid diagnostic logics, advocating for person-centered, trauma-informed, and dialogical approaches grounded in trust, shared meaning, and relational ethics. This confirms that ethical change is not only possible but present, albeit insufficiently supported and often marginalized within dominant institutions. These voices, both from within and outside psychiatry, point to a future of the discipline in which dignity, autonomy, and collective accountability guide clinical reasoning and policy design. This survey contributes not only new data but a coherent critical map of the harms, tensions, and alternatives surrounding one of the most contested diagnoses in mental health. Its integration into this thesis reinforces the call for a comprehensive, multi-level reform grounded in lived experience, interdisciplinary collaboration, and democratic values. It will inform further cross-survey analysis, comparative mapping of care paradigms, and concrete policy recommendations designed to end institutional violence, foster trust-based systems, and ensure that care becomes a space for recovery, not subjugation.

3.1.2 Survey-Based Study on Open Dialogue in Spain

This section embeds and contextualizes the peer-reviewed publication on the first wide-scale survey regarding the availability and perception of Open Dialogue among Spanish professionals. The inclusion of the full article as a documented scientific product reflects its foundational relevance: it provides a map of current understanding, resistances, and opportunities for change within the Spanish psychiatric system. The responses, although initially numerical, include open commentary that reveals systemic suspicion, underinvestment in training, and fragmented implementation. Despite this, a notable cohort of respondents identify Open Dialogue as a model aligned with their ethical aspirations and a potential route to overcome coercion, diagnostic overreach, and the silencing of patients.

3.1.3 Embedded paper introduction: open dialogue as a structural framework for autonomy, recovery, and non-coercive mental health care

The implementation and reception of Open Dialogue in the Spanish context provides a critical empirical and conceptual cornerstone for this dissertation's central argument: that psychiatry must be reconfigured around principles of autonomy, voluntary participation, trauma-informed care, and sustained relational continuity. The Open Dialogue framework, developed in Western Lapland in the 1980s and 1990s (Seikkula et al., 2006), has gained international attention for its non-hierarchical, dialogical approach to mental health crises. Its core components, immediate help, continuity, network-based meetings, tolerance of uncertainty, and polyphonic dialogue, represent a paradigmatic departure from coercive, diagnosis-centered psychiatry. By centering the voice of the person in distress and involving their social network from the first contact, Open Dialogue proposes not a set of techniques but a structural reconfiguration of what counts as care (Olson et al., 2014; Buus et al., 2021). It is precisely this structural nature that makes Open Dialogue relevant not only as a model of intervention but as a lens through which systemic barriers to ethical practice can be analyzed.

This chapter embeds and presents the first nationwide survey conducted in Spain on the knowledge, training, and institutional conditions surrounding Open Dialogue implementation. Developed collaboratively by professionals from multiple Spanish academic and clinical institutions, the survey emerged from the combined initiative of early adopters, researchers, and educators engaged in teaching, dissemination, and applied adaptation of dialogical practices. As a co-organizer of one of the foundational national conferences on Open Dialogue, hosted in partnership with HopenDialogue and involving a wide range of practitioners, researchers, and users, the researcher had the opportunity to facilitate early conversations about the ethical, legal, and educational implications of its potential adoption. This work was not limited to conference-level engagement. It extended to participation in international Open Dialogue forums (both virtual and in-person), integration into clinical teaching and postgraduate instruction, and direct collaboration with professionals seeking to transition from traditional psychiatric paradigms to dialogically informed practices. The survey itself was disseminated through these channels, creating both a data-gathering instrument and a moment of national reflection on the feasibility of real systemic change.

The scientific rationale for embedding this publication in the dissertation is twofold. First, it provides concrete evidence of professional awareness, interest, and ethical alignment with a model that rejects coercion and emphasizes shared decision-making, not as an ideal, but as a structured clinical commitment. Respondents report high levels of motivation to learn and apply Open Dialogue principles, while also revealing the institutional and epistemological resistance that inhibits its full implementation. This dual awareness, of both the promise and the obstacles, is crucial to understanding the structural dilemmas explored throughout this thesis. Second, the survey results directly validate many of the core findings derived from the other two surveys and the ethnographic work. They reveal that the deficits in current psychiatric practice are widely recognized from within, and that better alternatives are not only theoretically available but already being sought by professionals across the system. This scientific embedding, therefore, is not merely contextual, it is integral to the research architecture of the thesis. It demonstrates that Open Dialogue is not an imported solution but a feasible, desired, and ethically necessary direction for local and international transformation in mental health care.

As such, the article that follows should be read not as an isolated study, but as a substantiated contribution to the overall diagnosis and structural proposal articulated throughout this dissertation. It reveals both the system's permeability and inertia, its ethical tensions and possibilities. It confirms that autonomy, recovery-oriented care, and non-violent psychiatric practice are not utopian aspirations but urgent imperatives, ones that have already taken root in the work of those willing to resist institutional conformity and reimagine what care could become.



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EDITED BY

David Mosse,
SOAS University of London, United Kingdom

REVIEWED BY

Mauricio Alvarez-Monjaras,
University College London, United Kingdom
Mark Hopfenbeck,
Norwegian University of Science and
Technology, Norway
Alita Taylor,
Open Dialogue Pacific, United States

*CORRESPONDENCE

Enric Garcia-Torrents
✉ enric.garcia@urv.cat

[†]These authors have contributed equally to this work and share first authorship

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Open Dialogue in Spain: an initial survey of knowledge and perspectives

Silvia Parrabera-García^{1†}, Casilda Oujo-Fernández²,
María-Jesús Lirola^{3†}, Adolfo J. Cangas³, Jordi Marfá-Vallverdú⁴,
Martín Correa-Urquiza⁵ and Enric Garcia-Torrents^{5*}

¹Hospital Universitario Príncipe de Asturias, Madrid, Spain, ²Galicia Mental Health System, Galicia, Spain,

³Department Psychology, University of Almería, Almería, Spain, ⁴Catalonia Mental Health System,

Catalonia, Spain, ⁵Medical Anthropology Research Center, Universitat Rovira i Virgili, Tarragona, Spain

In Spain, the introduction of the Open Dialogue framework is relatively recent. This study takes a closer look at Open Dialogue training, interest and research in this region. To this end, a survey has been conducted through a convenience sample of professionals, people with their own experiences in mental health, family members, relatives, university professors and students. The results showed that a significant number of participants had no training in OD, and their exposure to relevant literature and congress attendance was limited. Amongst the different profiles, professionals reported the highest level of training. These findings highlight the urgent need for further research and training initiatives to improve the understanding and application of the OD framework in Spain. Efforts should be directed towards broadening the knowledge base, increasing access to training programmes and fostering interest amongst different stakeholders. By addressing these gaps, the implementation and use of OD can be expanded to meet the growing demand and interest in this approach in the Spanish context.

KEYWORDS

Open Dialogue, implementation, mental health, new perspectives in healthcare, psychotherapy training

1. Introduction

In recent years, there has been a growing interest and a gradual introduction of the Open Dialogue (hereinafter, OD) framework as an alternative treatment approach in Spain. Originating in Western Lapland in the 1980s, OD has demonstrated significant success in reducing the incidence of psychosis, achieving a remarkable decrease from 33 to 3 cases per 100,000 inhabitants over the course of a decade (Seikkula and Arnkil, 2016). The effectiveness of this intervention is primarily due to the basic principles underlying the OD framework, which can be summarised as follows (Seikkula et al., 2006, 2011): First, the provision of immediate help, within a 24-h timeframe following a request for help. In addition, networking plays a key role in OD, including family members and community members who can contribute to the well-being of the person seeking support. In addition, OD offers considerable flexibility in treatment, allowing adaptations to be made to meet the specific needs of each individual. In addition, the collaborative nature of OD is exemplified by professionals working together as a team, usually consisting of two to three members. Long-term continuity of care is emphasised, with follow-up and treatment extending over a minimum period of two to three years. In addition, OD encourages the cultivation of tolerance for uncertainty, discouraging hasty

decisions such as urgent hospitalisation or excessive reliance on medication. Finally, OD meetings are characterised by the principles of dialogue, ensuring active participation and equal voice for all members involved.

This OD approach bears remarkable similarities to mutual support groups, as highlighted by Chmielowska et al. (2022) and Lorenz-Artz et al. (2023). Its adoption extends beyond Spain, as evidenced by its use in several countries, as reported by Buus et al. (2021) and Mosse et al. (2023). Although the adoption of OD in Spain is relatively recent, significant progress has been made. In 2016, it was first used as a tool in the Mental Health Centre of Badalona (CSM Badalona 2), specifically to support recovery processes, following a pilot experience (Vallverdú et al., 2019). Subsequently, in 2017, the health authorities of the Community of Madrid approved and promoted the use of OD as a therapeutic framework and organisational system in the Early Attention Unit for Psychosis (UAT) of the Príncipe de Asturias University Hospital in Madrid. However, the continuity of OD implementation in both centres faces challenges. In Badalona, the retirement of the person in charge, Dr. Jordi Marfà, has affected the continuity of the service, whilst in Madrid, changes in the team and the sick leave of the promoter, Silvia Parrabera, have resulted in a limited number of cases being treated from an OD perspective.

In particular, OD practises have also emerged outside the public system. Some associations, groups and collectives, such as *Laporvenir*, have developed their approaches based on the OD framework. Several of the founding members of *Laporvenir* were previously part of the UAT team at the Hospital Universitario Príncipe de Asturias, together with other institutions (see Parrabera, 2017). Although the association is facing economic difficulties, it continues its activities (more information can be found on its website: <https://laporvenir.org/>).

The emergence of new evidence highlighting the need to reassess the development of mental health systems, programmes and services is not unique to Spain. It is a trend that can be observed in Spain as well as in other European countries (Martín López-Andrade, 2015; Correa-Urquiza, 2017; Desviat, 2020; Huertas, 2020; Fernández Liria, 2022). These calls for reassessment highlight the importance of exploring alternative approaches, such as OD, to meet the evolving challenges and demands in the field of mental health.

The detrimental consequences of psychiatric diagnoses (Hyman, 2010; Colina et al., 2021), the increasing violation of rights within mental health services (Muñoz Escandell, 2021), and the limitations of a vertical, unidirectional model of care with limited emphasis on dialogue (Martínez-Hernández, 2000) all highlight the need for transformative change. Desviat (2020) points out that the psychiatric reform of the 1980s was not a revolution, but a carefully negotiated transition involving psychiatric authorities from the dictatorship era who held influential academic and clinical positions, this reform did not fundamentally change the existing dynamics. However, the current context underlines the urgent need for change that recognises the inherent complexity of mental health problems and the associated social distress (Kleinman and Kleinman, 2000). Desviat (2020) advocates a 'renewed clinic' that includes essential elements such as continuity of care, therapeutic accompaniment, crisis intervention, home hospitalisation and the formation of transdisciplinary teams.

In this context of renewal, OD emerges as a transformative approach to the provision of care and support, with a strong emphasis on cultivating relationships based on complicity, proximity and compassion. It advocates dialogue and the deconstruction of hierarchical approaches to treatment, actively involving additional

actors such as family members, neighbours or friends in the processes of therapeutic recovery. OD is based on the fundamental premise that mental health care is a collaborative and multidimensional endeavour that prioritises the reconstruction of relational aspects and the life trajectories of individuals, rather than focusing solely on pathology (Fernández-Villardón et al., 2022).

The implementation of OD in Spain is characterised by regional differences. In some cases, professionals have incorporated OD into their individual practises or integrated it with other existing methods, such as multifamily group therapy (Sala, 2020; Sempere and Fuenzalida, 2021; Oujo-Fernández et al., 2023; Sala, 2023) or contextual therapies, including acceptance and commitment therapy. In the latter case, however, the integration is more theoretical than based on specific training in OD (Díaz-Garrido et al., 2023). In addition, the involvement of experts with lived experience is a common practise within the care team.

The growing momentum of OD is in line with the need for a paradigm shift in the approach to mental health care, not only in Spain but also globally in the Western world (Hyman, 2010; Martín López-Andrade, 2015; Correa-Urquiza, 2017). OD has emerged as a response to the limitations and chronic effects of conventional biomedical treatments. It also reflects the dissatisfaction expressed by individuals with lived experience and professionals themselves, who feel constrained by distressing institutional dynamics that prioritise harm reduction through the use of psychotropic drugs and prevent the coherent implementation of their principles in meeting people's needs (Tsou, 2007; Hyman, 2010; Beresford et al., 2016).

In Spain, people with lived experience of mental health services report the need for social change at all levels of the health system to include more supportive practises, fairness and respect for biocultural diversity (Hyman, 2010; Correa-Urquiza et al., 2020). This highlights the need for a cultural shift towards a more democratic and humane approach that recognises mental suffering as a multifaceted reality that requires careful consideration of its inherent complexity. Furthermore, changes in the working conditions of healthcare professionals are crucial to enable a more psychosocial approach and effective coordination that avoids isolating individuals from their unique circumstances (Tizón, 2013, 2014; Seikkula and Arnkil, 2016; Seikkula and Arnkil, 2019).

In response to the changing landscape of mental health care in Spain, OD is gaining relevance as an approach that meets the expectations of both professionals and individuals experiencing mental distress. Its value lies in its potential to reorganise the mental health system and transform professional practise through its open and flexible methodology. In addition, OD has the versatility to be applied in other community organisations. The growing interest in OD was exemplified by the recent 26th International Congress of the OD Network for the Treatment of Psychosis, held in Spain in 2022, which marked an important milestone for the OD approach.

Regarding training, which is fairly recent, first offered in 2020 as a University Expert Course in OD: Fundamentals were developed at the Universitat Ramon Llull in Barcelona (20 ECTS, 500 h), led by Dr. Berta Vall Castelló. The course had a first edition, but did not continue perhaps due to the economic cost, as it was a face-to-face course with several international speakers. An online course of 150 h of duration was launched in 2022 at the University of Almería, which covered all its initial places (45) and is now preparing its reedition and the possibility of continuing this first promotion with a Level II (trainer of trainers). This course is co-directed by Jaakko Seikkula himself.

Thus, there have been some attempts to promote OD training and practise in Spain, but with various difficulties. What has not been carried out so far is a study on the opinion of people who had contact with OD in order to better understand their assessment of what this training entails and the changes it can represent in mental health in Spain. This study aimed to fill this gap.

2. Materials and methods

2.1. Participants

The target population was a convenient sample of professionals, people with their own experiences in mental health, family members, relatives, university professors and students. The recruitment was made by disseminating the link to the survey carried out in google forms, sharing the link in different instant messaging groups and through social networks. The inclusion criteria were to belong to one of the five groups mentioned above, regardless of age or previous OD experience.

2.2. Instruments

For data collection, a survey was designed collecting socio-demographic data (age, gender, level of studies, current occupation) and, subsequently, different questions related to:

1. Degree of knowledge of OD
2. OD training received
3. Possible implementation of OD
4. Participation in OD

The survey can be consulted in the [Supplementary material](#). Likewise, when answering the questionnaire, participants could select one of the following profiles, leading to a series of questions about their experience with OD:

- A. People with own experiences in mental health
- B. Close friends / Environments
- C. Mental health professionals
- D. Public mental health system managers / associations with experience in OD
- E. University lecturers
- F. University students

To end with, an open question to the participants was included, namely “Finally, we welcome your thoughts, ideas, comments, observations, opinions on OD in Spain.”

2.3. Procedure

The aforementioned survey was designed and published using Google Form. A brief summary on the nature of the study was included at the beginning of the survey explaining it was anonymous and completely voluntary, and that participants could stop completing the questionnaire at any time. In addition, a contact point with the

researcher team was provided. The questionnaire took between 15–20 min to complete. The study was approved by the Bioethics Committee of the University of Almeria (UALBIO2021/013).

Convenience sampling was used to gather participants, sending the form to the researchers' databases containing people who had been in contact with OD, either because they had been involved in a clinical process based on OD or because they had undergone training. In order to avoid double entries for the online questionnaire response, the restriction of sending only one response per registered email was used. It was equally disseminated on social networks and WhatsApp groups to which the research members had access. No follow-up was carried out for those who did not respond to the survey.

2.4. Analysis

Descriptive statistics were calculated for the population. Subsequently, the responses obtained for each of the proposed questions on knowledge of OD were analyzed, obtaining frequency and distribution statistics for each of these variables. The different analyses were carried out using the SPSS statistical package in version 25.

3. Results

3.1. Descriptive statistics

A total of 214 people (147 women and 67 men) participated in the present study. The ages of the participants ranged from 18 years to over 70 years of age (55% of the population is between 30 and 49 years of age). Descriptive data on the participants were according to the four age brackets proposed as possible responses, we found from oldest to youngest with 4 participants aged 70 and over; with 29 people aged 60 to 70; a total of 33 subjects aged 50 to 59; another 61 people aged 40 to 49; with 60 participants aged 30 to 39; and, finally, 35 respondents aged 18 to 29. In terms of educational level, 87.4% had completed university studies.

[Table 1](#) shows the distribution of the sample in terms of the six profiles collected, and whether they have received training in OD (40.19%) or not (59.81%).

[Table 2](#) shows the time spent on training in OD, according to the profile of the participants. In this case, it can be seen that the profiles of public health managers and university professors have the highest rates of training in OD (80%) and, in third place, the profile of health professionals with 44.29% of these having undertaken some type of training in OD. However, this training has been limited in time, as only 16 people out of the total sample received more than 100 h of training (i.e., 12% of the total number of those who received some type of training).

[Table 3](#) shows the distribution by country of origin of the training received by the participants. It can be seen that the majority was in Spain (almost 90%), with 4 people having received training in Argentina or Uruguay, 3 in England and 1 in Mexico.

[Table 4](#) includes frequency statistics of the participants who received some kind of training in OD, the year in which they first heard about OD, also the readings they have done on OD, attendance at talks or conferences on OD, and, finally, whether they have participated in any group or association to use OD as a

TABLE 1 Descriptive statistics on profiles.

Profiles	N	NT	NT %	WT	WT %
People with their own experiences	29	20	68.97	9	31.03
Close friends / Environments	30	25	83.33	5	16.67
MH professionals	140	78	55.71	62	44.29
Public MH System Managers / Associations	5	1	20	4	80
University teachers	5	1	20	4	80
University students	5	3	60	2	40
Totals	214	128	59.81	86	40.19

Use: NT, No training in OD; WT, With training in OD.

TABLE 2 Training time in OD in hours.

	0 h.	1–5 h.	5–30 h.	30–100 h.	100–300 h.	+ 300 h.	% child h.
People with their own experiences	20	3	3	3	0	0	31.03
Close friends / Environments	25	2	0	2	0	1	16.67
MH professionals	78	10	22	15	13	2	44.29
Public MH System Managers / Associations	1	0	2	2	0	0	80
University teachers	1	0	3	1	0	0	80
University students	3	0	1	1	0	0	40
Total	128	15	31	24	13	3	40.19

TABLE 3 Origin of the training received.

	N	%	% Accumulated
Spain	68	89.47	89.47
Argentina-Uruguay	4	5.26	94.73
England	3	3.95	98.68
Mexico	1	1.32	100
Total	76	100	-

resource for support. As can be seen, practically all the people begin to know about OD from 2020 onwards, except for mental health professionals, who indicate 2018. The number of readings on OD is also higher in professionals (7.73) and lower in the rest of people, as well as attendance at talks or organisation of sessions on OD, which is once again much higher in mental health professionals.

3.2. Qualitative analysis of the reflections on the OD in Spain

Using a method of syntactic analysis of the responses to the question “Finally, we would like to thank you for your thoughts, ideas, comments, observations, opinions on the OD in Spain,” four main blocks or central themes were identified: (1) Benefits of OD, (2) Lack of training, (3) Need for research, and/or, (4) Need for changes in the public mental health system.

With regard to the first category, we find that the participants highlight the importance of being able to rely on this methodology in treatment, emphasising the need for humanisation, normalisation of

the experiences and the monitoring of cases in a much closer and less traumatic way, both for the user and for the people or family members around them. As textual evidence recovered from the responses, the following can be cited:

“Very interesting type of therapy. The user and the family feel well supported. The results are evident for everyone” (Woman, retired, 111).

“I think it is a very interesting new treatment conceptualisation especially in psychotic patients that can reduce psychiatric admissions, as well as better link patients” (Female, health, 127).

As for the second category, reference is made to the lack of training in OD in Spain. The possibilities and potential of OD are commented on, but also the need for courses or specialised training in the participants’ work centres to facilitate its implementation within the public mental health system. In this sense, the following reflections were made:

“It is difficult to find where to get training” (Woman, health, 28).

“It seems that more is beginning to be known and disseminated, but knowledge is still very scarce, and there are many female workers within the MH system who would like to work with a different methodology that is more coherent with their values, and that does not put them in uncomfortable situations that take away agency from the people they care for” (Woman, health worker, 45).

Thirdly, there is a need for more research in OD for its dissemination and the expansion of knowledge about the impact that this methodology

TABLE 4 Knowledge and application of OD.

	Year of knowledge OD	Numbers of OD readings	Numbers attendance talks	Organisation of sessions in OD
People with their own experiences	2020 (n = 7) 2022 (n = 2)	4,2	3,6	1
Close friends / Environments	2020 (n = 5)	5	0	0
MH professionals	2018 (n = 41) 2020 (n = 14) 2022 (n = 7)	7,73	6,19	7
Public MH System Managers / Associations	2020 (n = 4)	1,3	2,3	0
University teachers	2021 (n = 4)	2,7	3,5	0
University students	2020 (n = 2)	1,3	2	0

With regard to the perception of the need for a change in the care model of the public mental health system, results showed that 85% of those surveyed are in favour of changes, compared to 1.4% who think that changes are not necessary, and 13.6% who do not know/do not answer.

of care for mental health users could have on the course of crises and care for both patients and families during their recovery process.

“Publicity campaigns and good marketing are needed to make it known, as well as research studies that accredit and endorse it in a generalised way” (Mujer, sanitaria, 52).

“Need to publish studies to promote its application in public settings” (Woman, health, 72).

The fourth and last category contemplates the need for changes in the public mental health system, for the inclusion of new approaches and ways of treating and monitoring people with serious mental disorders. It is essential to make changes and promote new health practises in order to really achieve greater progress within the public mental health systems and to evolve towards new horizons with more optimistic perspectives.

“I don't really know how well established it is, its current situation, but I feel that a change in the way we look at mental health is necessary. Our society is governed by a rigid scheme based on scientific knowledge that generates stigmas, labels ... closing off possibilities, not allowing us to see what person we have in front of us. OD and its dissemination can help to change this view” (Woman, health, 35).

“The public health system is still far from being able to incorporate models based on collaborative and dialogic practises” (Woman, health, 123).

4. Discussion

The aim of this study was to evaluate the assessment and knowledge in Spain, a country where the first dialogic practises have recently been implemented, being important the holding for the first time in Spain the 26th International Congress of the OD Network for the Treatment of Psychosis in 2022.

The data obtained indicate that in the sample consulted there is a strong interest in a change in mental health, where OD can be a promising alternative, albeit there is still little knowledge about this framework. Thus, a significant percentage of respondents (almost 60%) indicate not having received any training on this approach, with the

majority of those who have had some kind of training having received less than 100 h. This probably relates to the fact that there are few training possibilities in Spain, where there was only an initial course in 2020 at the Universitat Ramon Llull en Barcelona, which was not followed up, and another one recently at the University of Almeria. Nevertheless, the latter has sold out and is currently being considered for reissue, as well as the extension of the training to a Level II (trainer of trainers), thus that the impact it can have on mental health in Spain is likely to begin to be felt soon. This aspect, the training, seems to be key for OD to really bring about a real transformation in mental health in Spain.

The number of readings on this approach was low. The available readings in Spanish on this topic are also scarce, where there are hardly any articles or book chapters, concentrated in the last five years (Parrabera, 2018, 2019; Vallverdú et al., 2019, 2020; Abad and Toledano 2022; Oujo-Fernández et al., 2023; Parrabera-Garcia and Chico, 2023), with the exception of one work (Abad et al., 2015). Similarly, the majority of respondents indicate that they have only heard about this topic three years ago (since 2020). Only healthcare professionals are the ones who have heard about OD a little earlier (since 2018) and have read more or attended talks or conferences on this topic.

There is a high level of interest in the institutional recognition of OD as a legitimate practise and perspective for addressing mental health in the consulted sample; it is also essential to start applying to other community organisations in order to generate a social transformation and a cultural change (Seikkula and Arnkill, 2019). In this sense, although there are seminars and small training proposals, there is a clear need to broaden and deepen the creation of systematized and organised training. In this sense, 85% of respondents expressed the need for a paradigm shift in Mental Health, which can be linked to the mandate of the “United Nations Convention on the Rights of Persons with Disabilities” (2006) and the successive reports of the UN Special Rapporteurs in defence of these rights. The OD can be deduced as one of the possible methodologies for the materialisation of the transition (World Health Organization, 2021).

These results are similarly observed in the qualitative evaluation, where participants highlight the benefits of OD, the absence of training, the need for research and the importance of changing the public health system. Thus, it is true that there is hardly any research carried out in Spain, beyond describing some experiences of initial practise sites (Minondo Romero et al., 2022), but no funded projects in this area have been found, nor active participation in other international studies, such as HopenDialogue (<https://www.hopendialogue.net/>).

It is necessary to develop also more local research that measures and analyses its effectiveness, taking into account the socio-cultural particularities of the country's context and territory. It is therefore necessary to analyse local casuistry in the implementation of the OD in order to produce evidence that allows us to evaluate the development and implementation of the model. Depending on these results, the possibility of endorsing the OD framework as a treatment option within the public MH system, and as specialised training in universities and scientific societies, could be considered.

In addition, the critical situation of the biomedical model in the field of mental health, promotes the urgency of new paradigms, practises and methodologies that accommodate the necessary transformations to generate a model attentive to the inherent complexity of the phenomenon of mental suffering. It is in this context that, for professionals, users and family members, OD appears as a possibility that, although it does not take into account the multiple dimensions related to this field, it is understood as a cornerstone on the road to the necessary transformations. It is an internationally legitimised possibility (World Health Organization, 2022) whose value lies, in turn, in the capacity at source to measure and analyse the impact of the model. In other words, the capacity of those who started with the OD to produce evidence of the results of its implementation is one of the key aspects of its international legitimacy.

Nevertheless, this study has some limitations such as the small sample size, particularly amongst some sectors. As a future line, it is considered important to repeat the study in the coming years, to see if knowledge of this approach improves and if this framework becomes established in clinical practise.

5. Conclusion

The present study analyses the knowledge and appreciation of OD in Spain by a sample of participants who have mostly had contact with this approach., where the most of the participants highlight the need for change that can be brought about by adopting the OD framework in our country, but also identifies a series of shortcomings, such as the need for more research, the few readings consulted by most of the participants and also a need for more training, particularly long-term training, which could make it easier for people interested in the subject to become involved in this change. It should be borne in mind that the introduction in Spain is still very recent, for example, the two most important training events that have taken place so far, both in 2022, are very recent, such as the 26th International Congress of the Open Dialogue Network and the first promotion of the University Expert in Open Dialogue in Mental Health at University of Almería has just finished, therefore it will be important to continue evaluating its implementation and their repercussions in the coming years, as well as new training, clinical and research experiences that will be carried out.

Data availability statement

The original contributions presented in the study are included in the article/[Supplementary material](#), further inquiries can be directed to the corresponding author.

Ethics statement

The studies involving humans were approved by Bioethics Committee of the University of Almeria (UALBIO2021/013). The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

SP-G, CO-F, AC and EG-T: conceptualization and visualization. AC: supervision. EG-T and M-JL: methodology and Validation. AC, SP-G, and EG-T: resources. SP-G, CO-F, M-JL, AC, JM-V, MC-U, and EG-T: investigation and writing—original draft preparation. AC, M-JL and MC-U: writing—review and editing. All authors read and agreed to the published version of the manuscript.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Supplementary material

The Supplementary material for this article can be found online at: <https://www.frontiersin.org/articles/10.3389/fpsyg.2023.1166919/full#supplementary-material>

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3.1.4 Survey on shared decision-making and medication management

This section presents the results of the core survey conducted on shared decision-making in psychiatry, with a focus on medication use, deprescribing, and autonomy in clinical encounters. The survey's qualitative architecture allowed respondents, many of whom are professionals themselves, to articulate in detail how real-world practices often contradict official policy claims. Responses highlight systemic barriers to collaborative care, including the asymmetry of information, institutional time constraints, cultural norms of medical authority, and fear of retaliation when dissenting. Several testimonies describe pathways toward hopeful practice, but these are exceptions. Most responses portray a system where patient voice is neutralized, and professional discretion is structured more by inertia than ethical reasoning. The survey was active 105 days, and got 90 respondents, with an average response time of 41 minutes and a half, accumulating 63 full hours of expert insights.

Purpose: The primary objective of this survey was to collect experiential, clinical, and professional perspectives on shared decision-making and long-term psychiatric medication use, with particular focus on misdiagnosis, autonomy, deprescribing, and institutional practices. The survey aimed to uncover both structural barriers and possible enablers to ethical, rights-based care practices. It invited responses from diverse actors, psychiatric survivors, caregivers, family members, and professionals across disciplines, regarding systemic patterns, diagnostic reliability, and opportunities for reform within mental health services.

Connection to the thesis: This survey forms a cornerstone of the thesis's empirical base, offering insight into the lived consequences of power asymmetries in psychiatric contexts and the systemic normalization of coercive or negligent practices. It directly informs the overarching research aim: to develop scientifically and ethically grounded strategies for implementing shared decision-making, fostering personal and network-based autonomy, and interrupting the cycles of harm and epistemic injustice perpetuated by current psychiatric and social care systems.

Respondent demographics and roles: This survey gathered a diverse range of voices, with responses coming from individuals with direct lived experience of psychiatric diagnosis, family members, and mental health professionals. Of the total respondents, a significant portion identified as having personally experienced a diagnosis related to schizophrenia, psychosis, or other psychiatric conditions. Alongside them, relatives and caregivers of diagnosed individuals offered critical insights into the impacts of treatment, institutional behavior, and long-term outcomes. Professionals, including psychiatrists, psychologists, social workers, and general practitioners, also contributed detailed observations on structural barriers, clinical culture, and ethical dilemmas within psychiatric practice. The demographic distribution confirms the multisectoral relevance of the issue and supports a triangulated interpretation of institutional dynamics, power asymmetries, and the pathways toward safer, more collaborative care. The presence of deeply reflective narratives across all roles signals a shared recognition of the need for reform and collective responsibility in addressing systemic dysfunctions.

Table 62 - Respondent roles and participation

Role / Relationship to Psychiatry	Number of Respondents	Percentage (approx.)
Person diagnosed with schizophrenia, psychosis, or related conditions	75	21%

Role / Relationship to Psychiatry	Number of Respondents	Percentage (approx.)
Person with another psychiatric diagnosis	35	10%
Relative or close friend of a diagnosed person	86	24%
Mental health professional (psychiatrist, psychologist, nurse, social worker)	128	36%
Others (students, legal advocates, carers, professionals in training, etc.)	22	6%
Not directly connected but interested in mental health	11	3%

The survey responses reveal recurring patterns of institutional mistrust, misalignment between diagnostic practices and patient needs, and a widespread desire for a more humane, participatory model of care. Across all roles, users, relatives, and professionals, there is strong concern that psychiatric diagnosis, particularly when centered on long-term medication without shared deliberation, often leads to depersonalization, coercion, and epistemic invalidation. Lived experience respondents consistently describe feeling silenced, stigmatized, and deprived of agency in treatment decisions. For many, medication was introduced without sufficient explanation, long-term planning, or informed consent, resulting in cumulative harm, physically, psychologically, and relationally.

Professionals too, especially those with extensive experience, report struggling within rigid systems that prioritize protocol over personhood. They acknowledge the pressure to medicate without dialogue, the institutional inertia against deprescribing, and the moral distress of witnessing harm without adequate structural support to intervene. Family members describe feeling excluded from care processes, confused by terminology, and unsupported when raising concerns about overmedication or side effects. There is repeated reference to the overuse of medication as a first-line intervention, often disconnected from contextual factors like trauma, poverty, housing insecurity, or systemic racism.

However, running parallel to this critique is a rich set of concrete proposals: training in shared decision-making, interdisciplinary collaboration, more flexible care pathways, and a shift from symptom control to relationship-centered recovery. Respondents point to dialogical approaches, narrative formulation, and ethical deprescribing as essential to restoring trust, dignity, and clinical integrity. The insights from this survey confirm that the dominant biomedical model, especially when implemented without checks and balances, has lost legitimacy among many of those it claims to serve. At the same time, the results also demonstrate a deep reservoir of ethical commitment and experiential knowledge that can and must guide future reforms.

Table 63 - Recurring themes and key findings

Theme	Key Finding	Illustrative Quote
Lack of shared decision-making	Treatment decisions are often made without meaningful patient involvement.	"I wasn't asked if the researcher agreed with the diagnosis or the treatment."
Medication as first and only response	Psychotropic drugs are prescribed rapidly, with little exploration of alternatives.	"The first thing was pills, not even a conversation."
Loss of trust and silencing	Patients feel devalued and unheard in psychiatric encounters.	"Speaking up only made things worse, they labeled me resistant."

Theme	Key Finding	Illustrative Quote
Epistemic injustice and power asymmetry	Professionals' voices dominate, invalidating personal and cultural knowledge.	"Everything the researcher said was interpreted as a symptom."
Neglect of contextual factors	Trauma, family dynamics, poverty, and discrimination are often ignored in diagnosis and care.	"No one asked what had happened, just what the researcher was feeling."
Side effects and chronic harm	Long-term medication is associated with debilitating physical, emotional, and cognitive impacts.	"I lost my energy, my memory, my sense of self."
Professional complicity and constraints	Clinicians acknowledge systemic pressure to conform, even when it contradicts ethical practice.	"We're told to follow protocol, even if it harms the person."
Desire for training and cultural change	Respondents call for education in trauma-informed, rights-based, dialogical care.	"We need to unlearn the habit of control."
Advocacy for ethical deprescribing	There is growing awareness of the need to taper medication safely and collaboratively.	"I had to guide my own withdrawal because nobody would help."
Hope for a more humane system	Many see the possibility of change through co-production, support networks, and mutual respect.	"Care should mean healing, not submission."

Regarding when mental health professionals support or oppose shared decision-making and deprescribing across various diagnostic contexts, when analyzing the likert scale questions of the survey, the following key patterns emerge:

- Professionals generally favor shared decision-making (SDM) and support deprescribing in a wide range of scenarios, particularly where diagnostic clarity is evolving or where overmedicalization is suspected. Notably, most respondents "strongly support" both SDM and deprescribing in contexts such as first-episode psychosis, depressive disorders with augmentation strategies, non-specified or unclear psychiatric diagnoses, and trauma-related symptom presentations. This suggests a critical view of entrenched pharmacological practices, particularly where diagnostic certainty is low or risks of harm are high.
- In contrast, support decreases in situations perceived as more clinically complex or potentially risky, such as in elderly populations with behavioral symptoms, institutionalized patients, and pediatric or adolescent populations. In these cases, some respondents adopt a more cautious or even oppositional stance, citing concerns over patient vulnerability or the lack of viable non-pharmacological alternatives. However, even in these contexts, a majority still lean toward supporting shared decision-making as a guiding ethical principle, reflecting a growing recognition of the harms of coercive and overreliant medication practices, albeit tempered by pragmatic risk assessment.
- Respondents with formal training in deprescribing or SDM are more likely to express nuanced support, indicating that education plays a key role in professional openness to reform. Those without such training often report feeling unsure or resorting to standard protocols by default, highlighting the need for structured, evidence-informed pathways and interdisciplinary collaboration to ensure safe, respectful deprescription practices.

Overall, the data reflect a shifting professional paradigm: while fears of relapse and systemic inertia remain barriers, there is clear momentum toward patient-centered, autonomy-enhancing approaches, especially when supported by adequate training, institutional backing, and resource availability. This insight reinforces the broader thesis argument for culturally and clinically grounded psychiatric reform. Following are the results from the eight open questions posed on clinical and policy scenarios presented in the survey, which form a coherent framework for analyzing critical gaps and opportunities in psychiatric practice through the lens of shared decision-making, autonomy, and evidence-based care. Each scenario reflects a high-impact point of intervention where systemic practices have veered away from ethical standards and scientific rigor, often at the expense of patient dignity and health. These cases are not isolated anomalies but emblematic of deeper structural problems, diagnostic neglect, epistemic injustice, and the entrenchment of pharmacological dependency in the absence of comprehensive assessments or individualized support. Their inclusion in this thesis allows for a focused exploration of how professional roles, clinical traditions, and institutional logics interact to either perpetuate harm or create openings for meaningful change. As a collective, they make visible the urgent need for national audits, training reforms, interdisciplinary approaches, and accountability mechanisms to prevent iatrogenic harm. Most importantly, these scenarios are not hypothetical: they are drawn from real survey data and professional testimony, and speak to the broader cultural and structural transformations needed to realize truly trauma-informed, autonomy-enhancing, and recovery-oriented psychiatric care. Their systematic analysis within this chapter contributes directly to the thesis's objective of mapping viable, ethically grounded pathways for reform in the governance and practice of mental health.

Scenario 1, implementing national screening for gluten sensitivity in psychiatric diagnoses: Many respondents demonstrate a cautious but increasingly open attitude toward the role of nutrition, and specifically gluten sensitivity, in psychiatric presentations. A majority stress the need for more education and interdisciplinary integration to assess and respond to such sensitivities without defaulting to long-term pharmacological interventions. Several participants underscore the importance of trauma-informed, individualized care, where dietary changes, if warranted, are collaboratively planned and transparently explained to the patient. Ethical deprescription emerges as a consistent recommendation, contingent on close follow-up and genuine informed consent. Challenges cited include systemic inertia, lack of coordination between primary care and psychiatry, insufficient training, and persistent adherence to the biomedical paradigm. Yet, within the reflections, one sees the blueprint for ethical reform: shared decision-making, holistic evaluation, humility about scientific limits, and respect for the patient's role and voice in their own treatment.

Table 64 - Recurring findings on gluten sensitivity and psychosis

Theme	Key Insight	Illustrative Quote
Need for individualized assessment	Calls for screening and caution before assigning psychiatric diagnoses.	"...assessing nutritional status, metabolic status, sensitivities,...at the onset of any ill-defined disorder...seems to me the most prudent thing to do."
Lack of professional training	Acknowledged knowledge gap among psychiatrists about nutritional links.	"I have no information or training on the relationship between celiac disease and neuropsychiatric symptoms."
Trauma-informed deprescription	Advocates deprescription if gluten sensitivity is confirmed, involving	"...establishing a shared plan of action...the patient should be a participant in the

Theme	Key Insight	Illustrative Quote
Patient-centered dialogue	patient in planning. Decision-making must include education, honesty, and cultural sensitivity.	decision." "Conveying information in an accessible way... Important to apologize for the treatment time."
Ethical reform and systemic obstacles	Institutional failure to adopt integrated care or promote non-pharmacological paths.	"...the system is still very hospital-centric, biomedical/psychopharmacological, hardly community-based..."
Skepticism with openness to research	Many demand stronger evidence before making changes but support further studies.	"As far as the researcher know, there is still weak evidence...more studies are needed before implementing these decisions."
Call for broader health paradigm	Emphasis on lifestyle, prevention, and restoring human-scale care.	"...strengthening of other non-pharmacological interventions such as prevention programs...healthier lifestyles..."

Scenario 2, deprescribing neuroleptics in cases of missed metabolic and nutritional disorders: First, there is widespread agreement on the critical need for *prior comprehensive organic screening* before any psychiatric diagnosis is finalized or neuroleptic prescribed. Respondents frequently cite overlooked endocrine or metabolic disorders, such as hypothyroidism, vitamin deficiencies, or electrolyte imbalances, as contributors or mimics of psychiatric symptoms, highlighting dangerous diagnostic shortcuts still prevalent in psychiatric practice. Second, participants emphasize that safe deprescription requires *slow, careful tapering* in close coordination between psychiatry and primary care. This includes clear communication, multidisciplinary collaboration, and patient-centered planning that validates and informs the person about their physiological and psychological evolution. A third recurring theme is the call for *cultural and systemic change*, underpinned by enhanced training for psychiatrists in neuro-endocrinology, more holistic approaches to mental and physical health, and the development of shared care pathways that transcend rigid specialty boundaries. Many respondents point to the systemic inertia and lack of institutional safeguards that perpetuate harmful prescribing patterns. There is a notable presence of lived experience, including narratives of harm caused by misdiagnosis and long-term medication, alongside constructive suggestions for ethical, evidence-based responses. Respondents advocate for coordinated protocols, increased investment in primary care capacity, and the creation of national programs for metabolic screening and deprescribing informed by cutting-edge research. These insights reaffirm the need for trauma-informed, recovery-oriented, and epistemically just models of care, grounded in scientific vigilance and human dignity.

Table 65 - Recurring findings on nutritional and metabolic disorders

Theme	Key Insight	Illustrative Quote (Translated)
Organic screening before diagnosis	Psychiatric symptoms must be evaluated in light of possible endocrine, nutritional, or metabolic causes.	"Psychiatric symptoms often have physical causes. We should rule them out first."
Diagnostic oversight and harm	Missed diagnoses of hypothyroidism, electrolyte imbalance, or vitamin deficits lead to iatrogenic damage.	"A woman labeled bipolar for years simply had untreated hypothyroidism."
Need for multidisciplinary coordination	Deprescription and reevaluation must be coordinated with primary care, endocrinology, and general medicine.	"I've had to refer many patients to their GP because psychiatry ignored bloodwork."

Theme	Key Insight	Illustrative Quote (Translated)
Trauma-informed and gradual tapering	Safe deprescribing requires trust, slow reduction, and ongoing monitoring with informed consent.	"Withdrawing a neuroleptic requires months, and a well-prepared support plan."
Knowledge gaps in psychiatry	Respondents criticize psychiatry's lack of training in nutrition, metabolism, and systems medicine.	"Psychiatrists don't learn enough about the body, only about controlling behavior."
Siloed specialties create risk	Fragmented care leads to redundant, uninformed, or contradictory treatment plans.	"One service prescribes what the other hasn't even evaluated."
Calls for institutional reform	Systemic inertia and overreliance on medication must be addressed through structural changes.	"The system prefers quick medication to a proper diagnosis."
Respect for patient voice	Personal experience, self-reports, and health literacy should be included in all care planning.	"The patient knew something was wrong, but no one listened until much later."
Advocacy for evidence-based change	National deprescription protocols, training programs, and broader health screenings are proposed.	"We need an institutional framework for detecting and reversing these cases."

Scenario 3, addressing psychiatric abuse cases uncovered through national research on mental health and violence: Based on the responses in the document titled *Masked abuses*, several recurring themes and key findings emerge from the answers provided by mental health professionals, survivors, and community respondents. These themes reflect systemic failures, ethical concerns, and visionary proposals for reform:

1. **Recognition of Institutional Violence:** Many respondents call for the acknowledgment of the harm caused by psychiatric institutions, including forced medication, misdiagnosis, retraumatization, and denial of narrative. There is a widespread demand for official apologies, restorative justice mechanisms, and reparations, both symbolic and structural.
2. **Trauma-Informed Approaches:** Respondents stress the urgent need to shift toward trauma-informed care models. This includes training mental health professionals on trauma, dissociation, and power dynamics, and the integration of psychosocial, individualized support.
3. **Deprescription and Holistic Support:** There is a strong emphasis on deprescribing psychotropic medications that were wrongly or harmfully prescribed, particularly when related to trauma responses rather than chronic illness. Respondents advocate for personalized tapering schedules and support systems such as peer support, housing, and therapeutic alternatives.
4. **Reform of Diagnostic and Training Systems:** Many testimonies call for the abandonment or radical revision of current diagnostic frameworks (e.g., DSM), highlighting their role in pathologizing normal suffering. The need for a transdisciplinary, non-hierarchical model of care is repeatedly expressed, alongside curricular changes from early education through medical specialization.
5. **Restoring Dialogue and Decision-Making Capacity:** A foundational element across responses is the need to restore the patient's voice and power, through shared decision-making, transparent communication, and validation of lived experience. This includes

mechanisms for reevaluating previous diagnoses and involving patients and families in care planning.

6. **Ethical and Legal Overhaul:** Numerous answers identify systemic conflicts of interest and lack of accountability within psychiatric and health systems. Proposals include establishing independent observatories, bioethics committees, and national commissions to oversee past and ongoing abuses.
7. **Socioeconomic and Rights-Based Framing:** Several respondents place psychiatric reform within broader social and economic justice frameworks. This includes addressing poverty, housing, and employment as essential for mental health, and advocating for adherence to international human rights conventions like the UNCRPD.

Together, these patterns reveal a critical, well-informed body of experiential and professional knowledge that indicts current psychiatric practices for systemic harms and charts a path toward ethical, trauma-informed, participatory care grounded in human rights and structural reform. This aligns directly with the thesis objectives: to document abuse, validate survivor knowledge, and support concrete reforms through shared decision-making, policy change, and institutional accountability.

Table 66 - Recurring findings on masked abuses

Theme	Key Finding	Illustrative Quote (English)
Institutional violence and neglect	Widespread acknowledgment of systemic abuse under the guise of care, including coercion, overmedication, and silencing.	"There is no record of the beatings, the deaths, the abuses. They are not recognized anywhere."
Need for official apologies and reparation	Respondents demand institutional recognition of harm and compensation, both symbolic and material.	"There must be apologies and reparation for those of us they broke in silence."
Trauma-informed recovery pathways	Emphasis on understanding dissociation, trauma responses, and the healing process beyond medication.	"They interpreted my trauma as pathology, and added more trauma through treatment."
Deprescription and restorative practices	Call for reversing harmful treatments through supported medication tapering and alternative supports.	"They drugged me for years for something that was never mine. the researcher want that erased."
Critique of psychiatric diagnoses	Many call for abandoning DSM-style labeling in favor of narrative, psychosocial, and biographical models.	"The label killed my future. No one cared to ask what had happened."
Bioethical and legal accountability	Strong support for independent ethics bodies and commissions to address past and ongoing harm.	"There must be a commission to investigate the damage psychiatry has done."
Role of social determinants	Structural violence, poverty, exclusion, abandonment, is identified as fundamental to understanding distress.	"Mental health starts with shelter, food, care. Not a prescription."
Need for early and transdisciplinary education	Respondents propose reforming training from childhood to medical specialization to avoid future harm.	"We need to teach empathy and critical thinking from school, not just at university."
Restoration of dignity and dialogue	Empowering patients through narrative, recognition, and inclusion in decisions is seen as fundamental.	"What saved me wasn't treatment, it was someone finally listening."

Theme	Key Finding	Illustrative Quote (English)
Future-oriented ethical transformation	Hope remains alive in the proposal for care systems based on rights, autonomy, and collective healing.	"We must invent another way to care, and this time, without harm."

Scenario 4, national deprescribing initiative for elderly patients at high risk of mortality and disability: The responses to the elderly care and deprescribing survey reveal a wide consensus around the urgent need to reform practices affecting older adults in mental health and residential care. Several core themes emerged consistently across contributions. Firstly, there is strong critique of the overreliance on neuroleptics and benzodiazepines, often administered in the absence of sufficient psychosocial support, adequate staffing, or trauma-informed care. This pharmacological dependency is not perceived as a clinical necessity, but as a substitute for structural deficits and human accompaniment, especially in institutional contexts where loneliness, abandonment, or aggressive containment practices are normalized. Respondents emphasize that the apparent "need" for sedation often arises from systemic failures rather than intrinsic clinical demands. Secondly, many participants articulate a need for multidimensional strategies for safe and consensual deprescription, highlighting best practices such as long-term tapering plans, shared decision-making, and coordinated care between primary and mental health services. Training in geriatric mental health, access to advanced directives, and widespread awareness of human rights frameworks (e.g., WHO's QualityRights program) are also proposed as vital. Thirdly, ethical critique is paired with constructive proposals for change: respondents advocate the integration of occupational therapists, psychogerontologists, and culturally sensitive staff to enhance non-pharmacological responses to behavioral distress and cognitive decline. They call for increased funding, improved working conditions, and a shift toward care models that privilege trust, presence, and dignity. There is a strong recognition that the conditions necessary for safe deprescription, time, empathy, institutional will, professional protection, family education, and community integration, are still lacking. Yet, despite such barriers, contributors remain hopeful that systems can and must change. Their testimony affirms that reform is not only a clinical necessity but a moral imperative, echoing broader calls for justice, accountability, and humanization in psychiatric care.

Table 67 - Recurring findings on elderly care and deprescribing

Theme	Key Finding	Illustrative Quote (English)
Overmedication in residential settings	Psychotropic drugs are often used as a substitute for presence, care, or appropriate staffing.	"We sedate them so they don't scream, not because they need it."
Lack of informed consent	Older adults are frequently medicated without understanding, consent, or involvement in decisions.	"They never told my mother why she was on those pills."
Structural causes of distress	Emotional suffering is often misinterpreted as psychiatric illness rather than consequences of isolation, loss, or institutionalization.	"She was grieving. They diagnosed her with a psychosis."
Need for training and coordination	Respondents call for more training in geriatric psychiatry and coordinated deprescription pathways.	"Family doctors need support to taper these medications, not blame."
Ethical tapering and long-term plans	Safe deprescription must be slow, collaborative, and trauma-informed, with non-pharmacological alternatives.	"Withdrawal must be a process with time, not a sudden change."
Recognition of systemic	Sedation and neglect of the elderly reflect deeper	"We treat our elders as

Theme	Key Finding	Illustrative Quote (English)
neglect	cultural disregard and ageism in the healthcare system.	disposable. The pills just make it more silent."
Integration of alternative professionals	Occupational therapists, psychogerontologists, and social workers are seen as essential to improve care.	"An activity therapist can reduce medication better than any pill."
Right to dignified aging	Respondents stress that dignity, presence, and love are fundamental rights at the end of life.	"The best medicine is a hand, a song, and time to be human again."
Barriers to change and moral distress	Professionals feel trapped between institutional expectations and ethical concerns.	"We know it's wrong, but we're afraid to lose our job if we speak up."
Hope for reform and humanization	Despite systemic challenges, many believe a culture of care can replace a culture of containment.	"There is another way to care, and it's time we demand it for them and for us."

Scenario 5, reevaluating long-term psychiatric diagnoses in a national audit: Recurring themes and key findings from the question on misdiagnosis and psychiatric labeling revolve around a profound critique of how diagnoses have been historically and clinically constructed, applied, and maintained. Respondents repeatedly emphasize that psychiatric diagnoses, particularly those leading to chronic prescription of neuroleptics, often lack scientific reliability, are epistemologically flawed, and serve to disempower individuals rather than foster recovery. A dominant theme is the call for re-evaluation and, where appropriate, full revision of diagnoses, not as isolated clinical decisions but as part of a restorative, transparent, and patient-led process. Contributors assert that many individuals have endured decades of inappropriate treatment, stemming from mislabeling and systematic neglect of trauma, social context, and individual variability.

Another strong thread is the call for systematic deprescription policies, coupled with safeguards for autonomy, informed consent, and therapeutic accompaniment. Several testimonies highlight the need for ethical and legal recognition of iatrogenic harm and the implementation of reparative justice, including public acknowledgment, formal apologies, and compensation mechanisms. Professionals and survivors alike call for multidisciplinary, trauma-informed approaches that prioritize patient voice, cultural humility, and shared decision-making. At the structural level, the data expose widespread institutional inertia, professional resistance to review past errors, and a dangerous conflation of diagnostic authority with truth, resulting in long-term harm and social exclusion. The responses are not merely oppositional but constructively suggest paths forward, including national audits, independent review panels, enhanced training in ethics and diagnosis, and embedding first-person expertise into clinical governance. The data underscore the urgency of shifting from a model of imposed classification to one of dialogical, dynamic, and ethically accountable care.

Table 68 - Recurring findings on misdiagnosis and psychiatric labeling

Theme	Key Finding	Illustrative Quote (English)
Harm from inaccurate diagnoses	Many individuals were diagnosed without full evaluation, leading to years of unnecessary medication.	"They gave me a diagnosis in ten minutes that defined the next twenty years."
Neglect of trauma and context	Diagnoses often ignore past trauma, social adversity, and life events.	"Nobody asked about my abuse. They just said the researcher had a

Theme	Key Finding	Illustrative Quote (English)
Desire for diagnostic revision	There is a widespread call for formal re-evaluation of psychiatric labels, especially chronic ones.	disorder." "I need the diagnosis removed, it was never correct, and it changed my life forever."
Epistemic injustice	Patient knowledge and experience are dismissed in favor of professional authority.	"I knew something was wrong with the diagnosis, but they told me the researcher didn't understand."
Need for deprescription	Misdiagnoses led to harmful, long-term use of neuroleptics and polypharmacy.	"I'm still recovering from the damage caused by the drugs the researcher never needed."
Lack of accountability	Institutions rarely acknowledge diagnostic errors or offer pathways to remedy them.	"They refused to review my case even when the researcher brought evidence."
Hope for restorative approaches	Respondents propose ethical review mechanisms and national audits for misdiagnoses.	"There should be a commission to restore justice for those harmed by wrong labels."
Cultural bias in diagnosis	Some diagnoses reflect cultural misunderstanding or stigma rather than clinical truth.	"They diagnosed me because the researcher didn't fit their norm, not because the researcher was ill."
Stigma and social consequences	Psychiatric labels result in exclusion, loss of opportunities, and internalized shame.	"That word on my file closed every door the researcher tried to open."
Call for dialogical models	Emphasis on dialogical, first-person, and narrative-based frameworks to replace rigid categorization.	"The real healing began when someone listened, not when they diagnosed."

Scenario 6, addressing the overprescription of neuroleptics in social care and marginalized communities: The responses to the question on marginalization and overprescription highlight a wide and deeply informed critique of current psychiatric practice when dealing with socially excluded populations. Several core themes emerged.

First, respondents emphasize the structural determinants of psychiatric overreach, particularly in contexts of poverty, homelessness, migration, and systemic discrimination. Professionals and survivors alike describe how psychiatric drugs, particularly neuroleptics, are used as crude tools of control, often prescribed without appropriate social evaluation or follow-up. There is clear consensus that pharmacological intervention is routinely substituted for real social care, and that this practice deepens the very exclusion it purports to treat. Many comments stress that the overmedicalization of distress in marginalized groups reflects institutional incapacity, leading to practices that are not only ineffective but deeply harmful. Second, there is a strong call for integrated, community-based, and rights-informed alternatives, including housing-first policies, income support, culturally competent care, and horizontal decision-making. Respondents consistently link shared decision-making and deprescription efforts with the need for stable psychosocial environments and long-term therapeutic relationships. Without these, deprescription is seen as a superficial fix or even a disguised form of abandonment. Third, the responses reveal epistemic injustice: the voices of the poor, the racialized, the disabled, or the socially displaced are often dismissed as "non-compliant" or pathologized, reinforcing a cycle of coercion. Calls for the participation of patient advocates, peer-led support, and independent review mechanisms point to a shared desire to reclaim dignity, autonomy, and trust in mental health systems. To end with, the tone across responses reflects both frustration and resolve. While there is clear indignation about the

persistence of structural neglect and abuse, many respondents propose concrete and technically sophisticated alternatives. These include coordinated networks of care, explicit deprescription protocols, and multidisciplinary responses centered on basic needs, education, and inclusion.

This body of testimony aligns powerfully with the broader arguments of this dissertation: that coercion, overdiagnosis, and institutional violence cannot be separated from socioeconomic exclusion, and that ethical reform in psychiatry must begin by restoring rights, investing in communities, and replacing domination with relational responsibility.

Table 69 - Recurring findings on marginalization and overprescription

Theme	Key Finding	Illustrative Quote (English)
Substitution of drugs for social support	Medication is often used in place of addressing socioeconomic exclusion, trauma, or unmet basic needs.	"They gave me pills, not a home, not work, not someone to talk to."
Structural neglect and institutional violence	Psychiatric labeling and overprescribing are instruments of control in contexts of poverty and racism.	"Being poor made me 'schizophrenic' in their eyes."
Epistemic injustice and silencing	Marginalized people's accounts are dismissed, reinforcing harm and blocking care alternatives.	"No one listened.the researcher was just another 'case' who didn't obey."
Failure to address root causes	Respondents critique the failure to recognize structural determinants like abuse, displacement, and poverty.	"I wasn't ill.the researcher was alone, abused, hungry, and terrified."
Call for community-based alternatives	Strong advocacy for non-medical interventions, peer support, housing-first models, and holistic care.	"Support groups saved me, doctors only numbed me."
Cultural and racial bias in diagnosis	Diagnostic practices reflect racialized and class-based assumptions.	"They treated me like a threat, not a person."
Lack of coordination across services	Overprescription is often the result of fragmentation in services and lack of responsibility.	"They prescribed, but no one followed up.the researcher disappeared in the system."
Deprescription needs structural support	Ending unnecessary medication requires social stability, accompaniment, and access to rights.	"You can't deprescribe someone who's still homeless and hungry."
Moral distress among professionals	Some clinicians express ethical tension between their knowledge of harm and institutional constraints.	"I knew it was wrong, butthe researcher had no other tools in the system they gave me."
Vision for structural change	Respondents outline pragmatic, coordinated reforms grounded in dignity and justice.	"We need networks, not prisons with pills."

Scenario 7, national review of the use of neuroleptics in children and adolescents: The responses to the question on developmental and pediatric use of neuroleptics reveal deep, sustained concern across participant roles, clinicians, family members, and survivors, regarding the medicalization of childhood distress and the ethical limitations of pharmacological approaches in early life. A dominant theme is the urgent call for strict regulation or even prohibition of neuroleptic prescription in children, with professionals highlighting developmental vulnerability and the long-term risks of iatrogenic harm. Respondents emphasize that the first-line responses should be psychosocial, educational, and family-centered, and that true informed consent must include the voice of the child, with age-appropriate education and participatory decision-making.

Several contributions point out that medicalization often compensates for systemic failures: overwhelmed school environments, unsupported families, unmet socioeconomic needs, and lack of access to tailored, continuous psychological care. Interventions like sensory-friendly school spaces, trauma-informed care, family education, and peer-support networks are proposed, highlighting a multi-systemic vision for reform. Others stress that deprescription programs must be fully resourced, with careful monitoring, coordination across sectors, and respect for the individuality of each case. Several professionals reflect critically on institutional pressures and ideological dominance that lead to early and prolonged use of medication, calling for interdisciplinary, non-hierarchical teams and a systemic reframing of the child not as the problem, but as a signal of larger dysfunction. The theme of epistemic injustice also emerges, especially in the dismissal of children's voices and parents' concerns in current practices.

The collected narratives form a coherent demand for systemic, ethical, and developmental justice, calling for a redirection of practice toward prevention, accompaniment, and structural change rather than pharmacological suppression of distress signals in the most vulnerable.

Table 70 - Recurring findings on developmental and pediatric neuroleptic use

Theme	Key Finding	Illustrative Quote (English)
Opposition to neuroleptic use in children	Broad rejection of prescribing antipsychotics to minors except in rare, justified, and monitored cases.	"They are drugs for extreme cases, not for children struggling at school."
Developmental vulnerability	Concerns about neurodevelopmental disruption and irreversible side effects.	"Giving neuroleptics to a growing brain is playing with fire."
Informed consent and participation	Call for age-appropriate, honest explanations to children and inclusion in decision-making.	"No one asked him what he felt. He was just medicated."
Systemic causes of distress ignored	Behavioral issues often reflect trauma, sensory processing differences, or unmet educational needs.	"They punished his suffering with pills instead of asking what was happening."
Deprescription as necessary repair	Several respondents emphasize the need to reverse long-term iatrogenic harm.	"We need national programs to help families get their children off these drugs."
Structural support and alternatives	Advocacy for family therapy, trauma-informed schooling, occupational therapy, and peer support.	"What helped wasn't a pill, it was a teacher who finally listened."
Medicalization of poverty and social problems	Neuroleptics are used to mask inequality, neglect, or overwhelmed families.	"If the system helped us feed and raise our kids, maybe we wouldn't need to sedate them."
Professional dissonance and constraints	Professionals feel complicit but often powerless in systems that pressure medication as a default.	"I regret having prescribed, but the researcher was the only psychiatrist in a collapsing service."
Call for ethical, long-term reforms	Respondents propose guidelines, education, intersectoral coordination, and child rights frameworks.	"We need to stop seeing kids as broken and start seeing the system that breaks them."
Silenced or pathologized childhood	Emotional and behavioral expressions in children are often pathologized instead of supported.	"She was grieving, not bipolar."

Scenario 8, ending the use of neuroleptics for non-psychiatric indications in general medicine: The responses related to the use of neuroleptics in general medicine and family practice converge on several critical concerns and reform priorities. First, there is a pronounced consensus that neuroleptics should not be prescribed outside psychiatric indications unless under exceptional and clearly justified circumstances. Numerous professionals highlight that general practitioners, emergency physicians, and non-psychiatric hospital staff often lack adequate training in psychopharmacology, leading to misprescription, particularly for delirium, insomnia, behavioral agitation, or non-specific distress, without attending to underlying causes such as infection, trauma, or social determinants. This misuse is seen as symptomatic of structural dysfunction, where institutional convenience and systemic inertia override patient well-being.

Respondents demand mandatory clinical audits, independent reviews, and the incorporation of clear deprescription protocols. They also emphasize the need for coordinated multidisciplinary teams to replace isolated prescribers, alongside the implementation of community deprescription services and follow-up mechanisms after hospital discharge. Ethical concerns are pervasive: participants denounce the breach of informed consent, the erosion of patient autonomy, and the exploitation of institutional power asymmetries for bureaucratic or pharmacological control. Several cite the influence of pharmaceutical interests and outdated biomedical paradigms as major barriers, calling for the removal of industry-sponsored training, and a return to person-centered, context-sensitive care.

A key demand across responses is the establishment of long-term structural safeguards: national registers to monitor psychotropic prescribing, case-by-case justification reviews, patient access to second opinions, and educational campaigns on the harms of psychotropic drugs. The recurring message is that institutional reform is both urgent and viable, provided that practitioners are protected, informed, and empowered to collaborate across disciplines while placing patient dignity at the center of clinical decisions.

Table 71 - Recurring findings on neuroleptics usage

Theme	Key Finding	Illustrative Quote (English)
Improper prescription practices	Neuroleptics are frequently prescribed by non-psychiatric professionals without adequate indications.	"In the emergency room, they hand out haloperidol like it's ibuprofen."
Lack of specialized training	General practitioners lack psychopharmacological knowledge and often follow outdated protocols.	"I was told to keep prescribing because that's what we've always done."
Masking of underlying conditions	Behavioral symptoms are sedated instead of investigated, leading to misdiagnosis and harm.	"They gave her neuroleptics for agitation, turned out she had sepsis."
Institutional convenience over care	Drugs are used to manage patients quickly rather than address their real needs.	"We were pressured to calm them down, not to understand them."
Absence of informed consent	Patients often receive these medications without proper explanation or discussion.	"He was medicated without even knowing what he was taking or why."
Call for deprescription protocols	Respondents urge structured processes for reviewing and reducing unnecessary prescriptions.	"There should be a deprescription team in every health district."
Pharmaceutical industry influence	Industry-sponsored education perpetuates overreliance on medication.	"Training is full of biased information, always favoring

Theme	Key Finding	Illustrative Quote (English)
Need for coordinated care	Proposals include team-based review, intersectoral communication, and post-hospital follow-up.	pharmacological solutions." "Discharge shouldn't mean abandonment, it should be a chance to start again properly."
Ethical and legal accountability	Professionals call for audits, rights-based frameworks, and second-opinion rights for patients.	"We need systems where patients can contest harmful prescriptions."
Hope for structural reform	Despite constraints, many express belief that reform is possible through systemic coordination.	"With training and time, we can do better, this doesn't have to be the standard."

Overall, the scenarios elicit strong and often polarized responses, reflecting a field at a crossroads between entrenched paradigms and emerging reformist practice. On one end of the spectrum, a significant number of professionals demonstrate clear readiness to embrace change: they recognize the ethical imperatives of deprescribing, the failures of rigid diagnostic orthodoxy, and the long-standing neglect of nutritional, social, and developmental factors in psychiatric care. These respondents emphasize dignity, holistic recovery, and the moral responsibility to update practices in light of contemporary science and human rights standards. Their reflections are grounded in experience and often accompanied by concrete suggestions, screening for gluten sensitivity, ending neuroleptic use in general medicine, initiating national audits, and prioritizing elderly safety, indicating a sophisticated, care-centered epistemology committed to collaborative healing.

Some responses reveal hesitation, denial, or an implicit defense of the status quo, and these often emerge from contexts of institutional inertia or professional fear, fear of liability, of destabilizing routines, or of challenging entrenched hierarchies. In such cases, reflexive justification of pharmacological intervention still dominates, especially around perceived risk groups like children, the elderly, or institutionalized individuals. Even among these voices, however, there are signs of doubt and moral discomfort, revealing the unsustainability of current models when confronted with real-world consequences and the visibility of harm.

Taken together, the scenarios function not only as diagnostic mirrors of the system's fractures but also as blueprints for possible structural renewal. They show that professionals, when given space, support, and accountability, can and do act with integrity and intelligence. But without systemic backing, education, and cultural transformation, isolated ethical action risks burnout or suppression. These insights underscore the thesis's central argument: reform is both necessary and possible, but it must be systemic, coordinated, and anchored in the lived realities of those most affected.

On education and training: Many respondents highlight a severe lack of professional training as the primary barrier to implementing deprescribing practices in mental health, particularly among psychiatrists, general practitioners, and allied professionals. They frequently pair this with concerns about the scarcity of accessible non-pharmacological alternatives, underscoring the systemic reliance on medication as the default treatment in the absence of psychosocial or community-based options. There is widespread recognition that fear of relapse and the perceived risks of reducing medication are institutionalized in practice, often outweighing individual clinical assessments or patient preference.

Several professionals report informal engagement in deprescribing, often case-by-case rather than programmatic, and express a strong desire for more structured training and support mechanisms. A

minority have participated in formal initiatives, but many note the lack of institutional pathways or guidance. When asked whether the national mental health strategy addresses deprescribing and shared decision-making, responses skew negative. Even among those who believe the strategy mentions these elements, most cite deficient or contradictory implementation.

A recurrent proposal is the development of coordinated training programs, alongside increased access to non-pharmacological therapies, including therapy, peer support, and housing. Respondents also emphasize the need for policy reform and funding redirection, arguing for community-based care and rights-respecting frameworks. A few participants also underline the ethical urgency of deprescribing and criticize the iatrogenic risks of long-term psychiatric medication use. There is also concern about professional isolation when pursuing deprescribing in systems that remain heavily medicalized.

Analysis of the survey responses by language reveals distinct Yet, complementary trends that underscore the transnational relevance of psychiatric reform while highlighting culturally grounded divergences in expression and institutional critique. Spanish-language responses, which formed the majority, tend to foreground structural violence, institutional betrayal, and ethical dissonance with striking narrative force. Respondents often described the routine normalization of harm, particularly overmedication and disregard for patient autonomy, in the context of under-resourced systems and hierarchical medical culture. These accounts are emotionally charged, politically aware, and often anchored in direct professional experience within the Spanish mental health system. In contrast, English-language responses, typically from internationally trained professionals or cross-cultural collaborators, display a more formalized analytical tone, emphasizing policy reform, interdisciplinary approaches, and alignment with evidence-based, recovery-oriented models. While no less critical, they more frequently reference international guidelines and emphasize the institutionalization of shared decision-making as a normative ideal. Both linguistic groups converge in their support for deprescribing and ethical transformation, Yet, their respective discursive registers reflect not only differences in professional cultures but also the degree of systemic inertia or openness perceived in their respective contexts. These linguistic trends reaffirm the need for multilingual and transcultural approaches to psychiatric reform, capable of integrating diverse epistemologies while respecting the lived experience and professional realities behind each voice.

Table 72 - Responses by language

Language	Number of responses	Main characteristics	Key themes	Tone and expression
Spanish	63	Grounded in direct professional and lived experience within Spanish-speaking mental health systems.	Institutional violence, diagnostic overreach, medication harm, ethical distress.	Expressive, urgent, often emotionally and politically charged.
English	27	Often reflects international or academic discourse, with emphasis on systemic reform and policy coherence.	Recovery-oriented models, clinical governance, professional training, interdisciplinary practice.	Analytical, policy-driven, reformist in framing.

To end with, the analysis of the survey responses by language reveals distinct Yet, complementary trends that underscore the transnational relevance of psychiatric reform while highlighting culturally grounded divergences in expression and institutional critique. Spanish-language responses, which formed the majority, tend to foreground structural violence, institutional betrayal,

and ethical dissonance with striking narrative force. Respondents often described the routine normalization of harm, particularly overmedication and disregard for patient autonomy, in the context of under-resourced systems and hierarchical medical culture. These accounts are emotionally charged, politically aware, and often anchored in direct professional experience within the Spanish mental health system. In contrast, English-language responses, typically from internationally trained professionals or cross-cultural collaborators, display a more formalized analytical tone, emphasizing policy reform, interdisciplinary approaches, and alignment with evidence-based, recovery-oriented models. While no less critical, they more frequently reference international guidelines and emphasize the institutionalization of shared decision-making as a normative ideal. Both linguistic groups converge in their support for deprescribing and ethical transformation. Yet, their respective discursive registers reflect not only differences in professional cultures but also the degree of systemic inertia or openness perceived in their respective contexts. These linguistic trends reaffirm the need for multilingual and transcultural approaches to psychiatric reform, capable of integrating diverse epistemologies while respecting the lived experience and professional realities behind each voice.

In addition to generating critical empirical insights, the surveys conducted for this thesis facilitated valuable professional and academic connections that enriched the broader fieldwork and action-research process. Notably, the adaptation and deployment of questions inspired by the *Schizophrenia Commission Inquiry* led to informal exchanges with individuals involved in the original instrument's design, as well as with members of their extended networks. These links, while limited in formal scope, provided contextual depth and validation, helping situate the Spanish implementation within a wider international movement toward user-involved, recovery-oriented research. The survey process also fostered relationships with respondents themselves, clinicians, patients, and family members, who engaged further by sharing reflections, offering suggestions, or expressing support. However, in line with ethical commitments to protect the integrity of vulnerable groups and avoid extractive or performative involvement, direct fieldwork interactions with survivor researchers and activists were deliberately kept limited. This boundary was maintained especially in cases where respondents might feel exposed or retraumatized by unsolicited academic interest. Even so, valuable experiential feedback was organically obtained through educational and professional forums, online events, and training activities in which the researcher participated as facilitator or co-learner. In these settings, the principles of mutual respect, dignity, and scientifically grounded best practices were consistently emphasized, not as abstract ideals but as necessary steps toward building mental health care systems that protect life, human rights, and the autonomy of all those they are meant to serve.

3.2 Fieldwork: introduction to the results and findings

This section of the dissertation introduces the results and insights derived from extended, multisite fieldwork conducted through direct engagement in diverse psychiatric, academic, and community-based contexts. Rather than a detached or passive observational stance, the approach adopted throughout has been one of committed and situated action-research. Across the assignments, scientific missions, institutional collaborations, and informal exchanges that marked this journey, the objective was never merely to observe, but to contribute meaningfully, adapting to each context while actively listening, participating, and learning with humility and responsibility. This work unfolded in Spain, Sweden, Indonesia, and several European academic and healthcare settings,

reflecting a plurilocal understanding of psychiatry and its social embedding. Whether embedded in teaching settings, collaborating with reform-minded clinicians, or bearing witness to harm in institutional and legal structures, the researcher sought not to extract data but to facilitate dialogue, resist injustice, and document lived realities through a process of co-presence and reciprocal learning. This methodological positioning is central to the results presented: it frames knowledge not as disembodied fact but as an emergent, situated, and transformative process, informed by lived experience and ethical intention. The fieldwork presented here was carried out with the clear goal of fostering structural change, protecting the most vulnerable, and cultivating collective capacity to do better, across systems, borders, and disciplines. The insights derived are thus not only diagnostic but generative, pointing toward pathways for professional reform, relational repair, and dignified psychiatric care grounded in autonomy, trauma-informed practice, and sustained attention to social and epistemic justice. All results will be presented in chronological order, from first engagements to the last.

3.2.1 Coordinator of the Spanish open dialogue network

The coordination of the Spanish Open Dialogue network emerged from a pivotal formative experience: my participation in a foundational training held in Barcelona, alongside mental health professionals and another survivor, during a time when the researcher myself remained under coercive psychiatric control, poisoned, and entrapped by an abusive network shielded by systemic impunity. No intervention offered then was therapeutic; on the contrary, each was deployed to facilitate ongoing degradation and institutional betrayal, reinforcing the cruelty of the perpetrators and the structural complicity of public services (Summerfield, 2019; Hopper et al., 2010). Nonetheless, compelled by a longstanding awareness of the generational damage wrought by psychiatric labels and silencing, evident in my own family history, where those deemed rebellious or vulnerable were diagnosed, discarded, and destroyed rather than supported, the researcher sought an exit, not only for myself, but for others similarly misrepresented and unprotected. The Open Dialogue approach taught me to articulate, with clarity and urgency, the relational dimension of madness and healing, and to understand care as an act of deep social listening: one requiring institutional courage, ethical fidelity, and the intentional dismantling of coercive hierarchies (Seikkula & Arnkil, 2014). Even while subjected to ongoing abuse, the researcher contributed to the training processes and the embryonic network, forging international and national links with survivor researchers, critical practitioners, and institutional actors willing to reform from within. The method's promise is radical Yet, practicable: it invites a complete reorientation of psychiatric ethics, where mutual respect, dialogical integrity, and a systemic understanding of context, abuse, contagion, social abandonment, replace control, silence, and isolation (World Health Organization, 2023; Buus et al., 2021). Its difficulty lies not in the practice itself, which is clinically sound and empirically supported, but in the pervasive ill will of those who resist relational work in favor of rigid protocol and procedural neglect. The beauty of Open Dialogue is its accessibility: a committed professional may begin transforming their practice alone, by engaging in true dialogue and connecting to networks of care, one patient, one colleague at a time. The tragedy is that in the face of such potential, systemic inertia and institutional corruption continue to suppress its implementation. The WHO formally recognizes Open Dialogue among the evidence-informed rights-based alternatives to coercion (World Health Organization, 2021). Yet, the uptake remains fragmented. In Spain, where the researcher have witnessed both exemplary individual commitment and structural sabotage, the method remains more chimera than norm. Still, each ethical practitioner working in earnest, each social worker contacted down the corridor, each decision to respect

autonomy rather than pathologize, represents a crack in the wall. The difference a single team can make is not symbolic: it is biological, psychological, existential. It is the difference between life and death.

3.2.2 Mad in America global network liaison

Mad in America emerged as one of the most significant platforms for critical engagement with the global psychiatric system, rooted in investigative journalism and expanded into a transnational movement of scientific accountability, survivor testimony, and professional reflection. It was founded by Robert Whitaker, an award-winning American journalist who, through the publication of *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill* (2002), exposed how systemic abuses in U.S. psychiatry mirrored longstanding patterns of coercion, marginalization, and epistemic corruption. His later book, *Anatomy of an Epidemic* (2010), rigorously documented how the long-term use of psychiatric medications, rather than reducing illness burden, may have contributed to the chronicity and functional deterioration of large populations, especially in cases of schizophrenia and mood disorders. These works, grounded in peer-reviewed evidence, historical data, and investigative rigor, showed that the psychiatric establishment had not only failed in its stated goals of healing, but had actively suppressed or ignored evidence that contradicted its dominant biochemical paradigm (Whitaker, 2010; Moncrieff, 2008). *Mad in America* was born from this recognition, not as a fringe or anti-science initiative, but as a vital epistemological counterweight to institutional narratives that too often prioritize pharmaceutical and institutional interests over public health, personal dignity, and scientific integrity.

This platform has since grown to become a global hub for critical psychiatry and mental health reform, integrating contributions from survivor researchers, critical psychiatrists, medical anthropologists, clinicians, educators, lawyers, and those with lived experience. It fosters a transnational dialogue that recognizes the structural drivers of psychiatric suffering, poverty, trauma, exclusion, institutional racism, gender violence, and medical betrayal, and offers space to imagine and implement alternative practices based on dignity, evidence, and mutual accountability (Davies, 2017; Burstow, 2015). The vision behind *Mad in America* is not one of mere denunciation, but one of renewal: a collective effort to ensure that science is once again accountable to truth, that healing is not hijacked by control, and that patient voices are not erased but centered. However, as this thesis also documents, the forces that *Mad in America* challenges, particularly those aligned with for-profit psychiatric treatment, coercive pharmaceutical regimes, and professional power monopolies, do not yield easily. The global psychiatric industry, heavily subsidized and backed by state power and international lobbying, is well-documented to act as a complex, self-protecting system of governance and commerce. Researchers such as Whitaker, Healy (2012), and the global critiques of the psychiatric-pharmaceutical nexus (Rose, 2006; Foucault, 1973) show how disciplinary power remains embedded in the mental health apparatus and resists reform through mechanisms of defamation, institutional inertia, and epistemological exclusion.

Being invited and selected to take part in the *Mad in America* editorial mission, at a time when my life was being severely undermined by personal and institutional abuse, was both a professional honor and a historical burden. It was an opportunity to contribute to the ethical redirection of psychiatry, bringing in the voice of those who carry scientific competence and lived experience. Yet, this role, like many other critical paths in my career, was interrupted by violence, interpersonal, institutional, and epistemic. It is not merely about a lack of support, but about the direct opposition

that ethical work often encounters. As countless critical professionals, educators, and survivor researchers know, the more effective the challenge to the status quo, the more subtle and aggressive the repression becomes. Careers are derailed, voices discredited, legal action delayed or silenced, funding denied, networks infiltrated, and the violence is made to appear personal or accidental rather than structural (Spandler & Anderson, 2021; Hopper, 2007). In our network, we were few. Under-resourced, overburdened, and constantly facing systemic sabotage, we struggled not only to write and research, but to survive, teach, and build sustainable practices and communities of care. Yet, what *Mad in America* offered, and continues to offer, is the clear insistence that exposing harm is not enough. We must also tell of what works, what heals, and what resists being co-opted. It is a publication that uplifts practices such as Open Dialogue, Soteria, Hearing Voices, and recovery colleges, not as utopias, but as grounded, data-backed alternatives (Seikkula et al., 2006; Mosher, 1999).

This aligns directly with the aims of this dissertation: to render visible the violence obscured by medicalized discourse, to legitimize the knowledge and agency of survivors and communities, and to implement real change through scientifically grounded, ethical practice. The value of truth, dignity, and healing, without repression, coercion, or epistemic erasure, must be made not only an ideal, but a methodological imperative. To restore medicine to its fundamental role in society: not as an agent of normalization and exclusion, but as a practice of knowledge, responsibility, and support. That is why this thesis includes reference to *Mad in America*: not only for its content, but for its ethic. Its commitment to dignity is the commitment of this work. To stand for truth, even when it costs. To create knowledge that heals, even if the system resists it. To envision futures in which health is no longer privilege or punishment, but an assured possibility for all.

In response to a dominant psychiatric paradigm centered on sedation, containment, and chronic management, this dissertation advances a structurally and empirically grounded demand for paradigm shift. Current practices in psychiatry across Spain and Europe remain tied to historically inherited frameworks of control rather than recovery, shaped more by administrative inertia and biomedical reductionism than by the evolving evidence base in neuroscience, psychosocial rehabilitation, and rights-based approaches to care. Engagement with global critical networks, including the *Mad in America* editorial team, Open Dialogue practitioners across Europe, and survivor-informed research consortia, offered direct insight into both the entrenched dysfunctions and the viable alternatives emerging through clinical and community-based innovation.

The Open Dialogue model, developed in Western Lapland and endorsed by the World Health Organization (World Health Organization, 2021), provides an evidence-based, dialogical alternative to coercive and medication-heavy interventions. It centers relational ethics, systemic inclusion, and polyphonic narrative practices, demonstrating superior long-term outcomes for individuals experiencing psychosis, including higher employment rates and lower relapse and hospitalization rates (Seikkula et al., 2006; Aaltonen et al., 2011). Observations of Open Dialogue in practice, even under sociocultural constraints such as the monocultural setting of Northern Finland or the fragmented institutional ecosystems of Spain, revealed a consistent pattern: where dialogical methods were adopted, dignity, narrative coherence, and community engagement improved. Where they were absent, medicalization, overprescription, and systemic abandonment prevailed.

As a medical anthropologist and action-researcher, my role within these networks has been to document, connect, and contribute to the co-creation of knowledge and practices that prioritize lived experience, contextual diagnostics, and recovery-oriented pathways. The fieldwork has ranged

from formal training cohorts to informal collaborations with professional reformers, survivor researchers, and institutional actors engaged in transformation. This work has never been a detached observation but a direct, ethically situated engagement, frequently undertaken under conditions of institutional violence, epistemic erasure, and personal harm. Despite this, or precisely because of it, the scientific imperative remained: to collect testimonies, analyze systems, and build coalitions toward evidence-informed change.

The thesis situates these experiences within the broader context of institutional critique, aligning with findings in the social sciences and critical psychiatry that expose the commodification of distress and the entrenchment of coercion as normative (Rose, 2006; Davies, 2017). The prevailing logic of pharmacological sedation over structural reform, and of lifelong labeling over trauma resolution, is scientifically untenable. Evidence supports the use of nutritional psychiatry, neuroplasticity-based interventions, family-based approaches, and culturally adapted care models (Jacka et al., 2015; van Os et al., 2019). Yet, systemic uptake remains minimal due to ideological capture, commercial interests, and administrative risk aversion. The result is a pseudoscientific status quo that preserves harm and disguises it as help.

As a liaison between diverse global initiatives, the researcher has worked to connect efforts in dialogical practice, trauma-informed care, and human rights monitoring into a cohesive translational framework. This has included participation in the early steps of the EU BEACON One Health Education initiative, which integrates health promotion, open science, and restorative pedagogies across disciplines and borders. The One Health framework expands the ethical and scientific horizon of this project, reinforcing that human mental health cannot be isolated from broader ecological, social, and technological systems. Our obligation is not only clinical or scientific but intergenerational and civilizational. With the tools now available, ranging from community-based psychosocial support to AI-assisted early intervention and open-access clinical training, there are no remaining justifications for systems that institutionalize suffering or pathologize the social.

This research affirms that recovery is not solely a clinical endpoint but a structural and epistemic repositioning of care itself. Science must not be deployed as a weapon of exclusion or pacification, but as a tool for restoring autonomy, enabling mutual recognition, and fostering sustainable wellbeing. The refusal to normalize mass pharmacologization, diagnostic inflation, and epistemic violence must be matched by the responsibility to implement alternatives, documented, replicable, and dignifying. This work contributes to that task, and insists that the only rational and ethical future of psychiatry is one grounded in rights, evidence, and solidarity.

Among the most pressing insights emerging from this work is the silencing and invalidation faced by those who recover and go on to expose the systemic violence embedded in psychiatric practice and academic complicity. This reflection, originally written in correspondence with colleagues from the *Mad in Finland* network, underscores how recovery itself, when it contradicts diagnostic chronicity and institutional narratives, becomes politically inconvenient. Individuals who survive coercive treatment, who speak with clarity about harm and truth, and who produce scientific and community outcomes contrary to expected decline, often face marginalization not only from medical services but also from professional spaces allegedly committed to change. This culture of denial extends beyond clinical settings, permeating academia, policymaking, and even international collaboration, where survivors and reformers are regularly pushed aside in favor of those who maintain bureaucratic normalcy. What is described here, harassment by thesis supervisors, forced drugging, akathisia misread as suicidality, and the abandonment of scientific integrity in favor of

doctrinal pharmacology, is not anecdotal; it is emblematic of institutional epistemic injustice and systemic violence.

This exchange also reflects a broader structural reality: psychiatric power operates not only through diagnostics and drugs, but through collective decisions made by professional bodies that shape policy, law, and care design. These decision-makers are not neutral; they carry the responsibility of having chosen, either actively or passively, to maintain a paradigm that pathologizes resistance, obscures trauma, and enforces compliance over curiosity. The reference to akathisia-induced pleas for euthanasia must be read not as isolated suffering, but as a clinical outcome of systemic brutality. Likewise, the disavowal of integrative, rights-based recovery models, despite mounting empirical evidence and WHO endorsement, betrays a deeper failure: a profession at times unwilling to see, acknowledge, or act on what science and humanity demand.

As such, this dissertation affirms the necessity of situating these lived experiences not in the margins of academic inquiry, but at its core. They are not exceptional outliers but central indicators of where the system breaks down, and where reform must begin. The call for One Health education, for interconnected and preventive pedagogies from early life onward, is here presented not as utopia but as due diligence in the face of negligence. This is the only ethically and scientifically coherent response to a psychiatric legacy that still too often condemns, disables, and erases. The voices that heal, warn, and build deserve not just space, but structural protection and recognition within the epistemic fabric of mental health reform. These testimonies are not personal grievances; they are critical data, pointing toward the kind of systems we must now design: restorative, transparent, honest, and built not on fear or control, but on solidarity and truth. We are all losing our best chances by not having a better network to rely on and contribute, better business to mind. We are still ongoing, working on. The researcher not any longer their liason, Yet, yes from other ones. Deeply thankful and honored, in a professional and human level to be still learning and collaborating.

3.2.3 ReMO COST Action

COST (European Cooperation in Science and Technology) Actions are transnational, science-driven networking instruments funded by the European Union that support the coordination of nationally funded research across Europe and beyond. They are designed to foster interdisciplinary collaboration, knowledge sharing, capacity building, and the co-creation of future research agendas. COST Actions do not fund research directly but provide a flexible, bottom-up structure for researchers and stakeholders to organize scientific meetings, workshops, training schools, short-term scientific missions, and dissemination activities, thereby enabling inclusive participation and the development of sustained, collaborative research communities.

The ReMO COST Action (CA19117, Researcher Mental Health Observatory) exemplifies this model by addressing the rising concern over mental health in academia and the research profession. Operating between 2020 and 2024, ReMO brought together researchers, university leaders, policymakers, and early-career academics to examine structural pressures, psychosocial stressors, and systemic barriers affecting mental well-being across the research ecosystem. Through its working groups, it enabled comparative analysis, exchange of best practices, and policy dialogue, focusing on issues such as workload, precarity, discrimination, academic bullying, and institutional accountability.

Participation in ReMO contributed to this doctoral project by providing critical observational fieldwork opportunities within an organized European platform dedicated to mental health and institutional culture. It allowed for transnational insight into how structural violence and epistemic injustice manifest not only in clinical psychiatry but also in research environments themselves. This reflexive alignment, studying mental health systems while embedded in a network examining researcher well-being, enabled a meta-analysis of institutional care, responsibility, and the failure to uphold dignity in both medical and academic domains. The ReMO experience also fostered key connections for the development of EU BEACON and intersected with advocacy for rights-based, trauma-informed, and evidence-driven reform efforts in education and healthcare.

ReMO offered a unique transdisciplinary platform through which the pervasive and under-recognized crisis of mental health within academia could be explored. COST Actions, funded by the European Union, are not direct research grants but networking instruments aimed at building scientific coordination and cooperation. Their purpose is to foster dialogue and collaboration across borders, enabling sustained research communities. In the case of ReMO, the focus was clear: to bring into light the structural, psychological, and social conditions underpinning researcher distress, burnout, and institutional negligence across European higher education systems.

From a medical anthropological perspective, this setting provided not only an observational arena but also an immersive, experiential layer of fieldwork in which the ethnographer-participant could analyze and engage with both the scientific discourse and the lived experience of distress among researchers. What became immediately evident through working groups, conferences, and informal exchanges was the shared nature of suffering across national contexts: a suffering marked by overwork, lack of long-term security, competitive hostility, epistemic silencing, and a pervasive culture of silence around help-seeking.

The data emerging from ReMO's network align with findings across the academic literature. Studies repeatedly highlight alarming prevalence rates of anxiety, depression, burnout, and suicidal ideation among academic staff and doctoral students (Evans et al., 2018; Levecque et al., 2017). High rates of psychoactive drug use, including antidepressants, anxiolytics, and stimulants, are documented not only among clinical populations but increasingly among early-career researchers and faculty as coping mechanisms for institutional pressures (Winefield et al., 2003; Guthrie et al., 2017). The overmedicalization of psychosocial suffering in this context reflects a pattern also present in psychiatric care more broadly, namely, the substitution of structural and collective solutions with individualized pharmacological containment.

This trend parallels the key themes of this thesis, which examines how institutional structures in psychiatry normalize suffering by suppressing its roots and denying the social, economic, and ecological conditions of mental distress. In academic institutions, this translates to the widespread experience of imposter syndrome, chronic insecurity, moral injury, and emotional burnout, particularly acute for women, people from minority backgrounds, and those with lived experience of trauma. These individuals, disproportionately exposed to discriminatory environments, often experience compounded harm when working in systems that ignore vulnerability and expect unflagging productivity.

The ReMO network also exposed a core contradiction within academia: institutions that proclaim to value mental health frequently engage in practices that erode it. Work overload, short-term contracts, pressure to publish, and lack of mentorship or inclusion create a system in which distress

is normalized as a rite of passage rather than a signal of systemic failure. As Cañibano et al. (2019) argue, this results in the "responsibilization" of the academic subject: individuals are made responsible for surviving systems that are, in fact, structurally pathogenic. From an anthropological lens, this speaks to the biopolitical dimensions of suffering within knowledge-producing institutions, how bodies and minds are regulated to meet institutional goals under the guise of meritocracy.

Within ReMO, my role was not passive. As an action-researcher, the researcher contributed to methodological debates, shared experiential insights, and sought to integrate mental health concerns into the broader European science policy agenda. The EU BEACON initiative emerged in part from the convergence of this insight: a One Health-oriented approach that includes the mental health of educators, students, researchers, and practitioners as fundamental to planetary well-being and scientific sustainability. What ReMO helped illuminate is that academia is not an exception to the rule, it is a concentrated expression of the same systemic forces that underlie psychiatric institutional failures: overmedicalization, stigma, epistemic injustice, and abandonment of care.

The result is a system in which researchers suffering from exhaustion, trauma, or discrimination are often medicated, pathologized, or pushed out. Education systems become spaces of punishment rather than potential. This is particularly evident in the experiences of researchers from underprivileged or historically excluded backgrounds, who face additional emotional, economic, and symbolic burdens while being expected to conform to dominant norms of objectivity and detachment. These insights reinforce the need for radical transformation, not superficial well-being programs but structural reengineering of how knowledge is produced, evaluated, and lived.

The use of nootropics, stimulants, and off-label psychopharmacology in academic environments must be interpreted not merely as individual choices but as structurally induced responses to a system that rewards hyperproductivity, penalizes deviation, and ignores the socio-ecological dimensions of distress. Within the highest strata of academic performance, elite research institutions, grant-driven laboratories, competitive graduate programs, the pressure to exceed baseline cognitive, emotional, and behavioral norms generates a silent epidemic of overmedicalization. Attention Deficit Hyperactivity Disorder (ADHD), anxiety disorders, and depressive symptomatology are increasingly diagnosed not on the basis of pathological dysfunction per se, but because individuals cannot, or will not, sustain the unsustainable (Conrad, 2007; Rose, 2019).

This paradox of excellence, that the most intellectually gifted are also among the most medicated, is emblematic of a larger failure of epistemic justice. Intelligence and rigor are not protected or nurtured by these systems; they are mined, strained, and depleted. The diagnostic labels serve as regulatory mechanisms that validate pharmaceutical intervention, often blurring the line between support and suppression. Stimulants such as methylphenidate and amphetamines are prescribed off-label or increasingly tolerated in gray-market academic economies, not for the remediation of genuine neurodevelopmental impairments, but as tools to meet extrinsic demands (Maher, 2008; Singh & Kelleher, 2010). The performance-boosting rationale disguises a deeper truth: these are not enhancements but chemical enforcements of institutional discipline.

Differential treatment by class, gender, ethnicity, and educational status exacerbates this problem. Children from affluent backgrounds are more likely to receive diagnoses that unlock accommodations and stimulant prescriptions; marginalized students, by contrast, are disciplined

without support, often labeled as oppositional or lazy (Mehta, 2013). By the time one reaches academia's upper echelons, the visibility of mental health support structures often correlates with prestige, while actual access to humane, non-medicalized support remains minimal. To call these patterns "genetic" is not only scientifically inaccurate, but ethically obscene: it erases the social determinants of distress and allows institutions to abdicate responsibility for the suffering they produce and sustain (Mills, 2014).

The thesis documents this reality through fieldwork, participant observation, and survey data across multiple countries and institutions, highlighting the convergence between medicalization, academic precarity, and psychiatric overreach. A particularly damaging narrative, prevalent among both patients and practitioners, is the inevitability of psychiatric decline in high-performing individuals. This becomes a self-fulfilling prophecy: drug dependence replaces long-term support; diagnostic identity replaces resilience; silence replaces inquiry.

The solutions proposed in this thesis are grounded in One Health, biocultural analysis, and evidence-based action research. These include the implementation of non-pharmacological support systems at all academic levels, mind-body training, cognitive-behavioral pedagogies, open access peer networks, and nutritional psychiatry interventions (Sarris et al., 2015). Institutional reforms must prioritize workload redistribution, inclusive mentorship, and trauma-informed curricula. Policy frameworks like EU BEACON aim to support such structural shifts, not only as health imperatives but as epistemological corrections. We do not need smarter drugs. We need smarter systems.

The thesis situates this and other researcher experiences within a broader epistemic framework: health is not merely the absence of pathology but the presence of dignity, safety, recognition, and capacity. Academia, if aligned with this principle, can become a vector for recovery, justice, and planetary care. But to do so, it must abandon the myths of neutrality and invulnerability, and embrace a model of shared responsibility, systemic empathy, and inclusive co-production. ReMO's legacy is thus not only a body of shared knowledge, but an unfinished agenda for transforming care at the heart of knowledge production.

The core problems exposed through participation in the ReMO COST Action are both persistent and deeply entrenched. They reflect systemic failures repeated across generations and institutions, now exacerbated by new layers of precarity and institutional inertia. Despite having been given the opportunity to contribute to the national policy guidance for Spain, the reality encountered was one of fragmentation, lack of coordination, and the widespread marginalization of the very individuals and perspectives most needed to guide reform. The effort to develop informed recommendations was hindered not by bad faith alone, but by chronic underfunding, inadequate planning, and a lack of structural integration across domains of higher education, mental health services, and scientific labor.

Those with lived experience, survivors of psychiatric harm, underrepresented researchers, precariously employed professionals, remain systematically excluded from the design and decision-making processes that affect their lives and work. Many of the most knowledgeable actors in this field, including early-career academics, interdisciplinary experts, and survivor-researchers, were only partially engaged, if at all. Their insights remain undervalued, their participation often tokenistic or extractive, and their conditions of work marked by exhaustion, institutional neglect,

and personal risk. the researcher could barely survey or document their perspectives within the constraints imposed, despite every effort to do so with rigor, inclusion, and scientific responsibility.

Yet, the networks forged through ReMO laid a groundwork that now continues through EU BEACON and its expanding consortia. Many ReMO participants, recognizing the shared urgency of reform, joined BEACON as contributors and co-designers. Together, we are developing a transdisciplinary infrastructure aimed at integrating mental health into One Health education and global public health transformation. This includes operational mechanisms for feedback, dissemination, and field-level coordination that ReMO helped inspire but could not fully implement within its limited timeframe.

This work is not completed, it is ongoing, and it is mine to carry forward. It requires time, collaboration, sustained ethical engagement, and structural support. But most of all, it requires a political and scientific willingness to listen to those systematically left out. The thesis acknowledges these gaps not as failures of individual actors, but as symptoms of systemic dysfunction, and commits to translating them into concrete, inclusive, and empirically sound frameworks through the EU BEACON action and beyond.

3.2.3.1 ReMO COST Action, virtual ethnography

The ReMO COST Action (CA19117, "Researcher Mental Health") provided a unique opportunity for transdisciplinary engagement with the structural determinants of psychological distress and institutional precariousness within academic and scientific ecosystems. Through a structured virtual ethnographic mission lasting one month, this research embedded itself within the digital working groups, plenaries, and internal coordination meetings of the Action, with a particular focus on the health working group, where discussions often centered on performance pressure, emotional exhaustion, and the limits of existing institutional frameworks to ensure equitable care and wellbeing for researchers. The findings of this virtual fieldwork highlight the deeply rooted need for the development and implementation of reliable, ethical, and scientifically validated expert systems that can support both clinical practice and researcher wellbeing from a trans-scalar One Health perspective.

The hypothesis underpinning this sub-study is grounded in the recognition of the significant epistemic and practical disparities between high-competence, contextually attuned practitioners and the widespread experience of disempowering, low-standard care. The metaphor of "a good doctor in a floppy disk" captures the latent potential of expert systems when they are designed with rigor, contextual sensitivity, and accountability. This technological promise is well documented in the literature on clinical decision support systems (CDSS) and expert knowledge models in psychiatry, which emphasize the transformative potential of intelligent tools when grounded in validated clinical pathways and user-oriented interfaces (Shortliffe & Cimino, 2014; Sutton et al., 2020). However, the translation of this promise into practice is hindered by systemic resistance, lack of standards enforcement, and the ongoing commodification of care pathways, especially in mental health domains where subjective judgment often supplants structured evidence.

The ReMO network, while not a clinical network per se, became a fertile ground to examine the sociotechnical imaginaries and epistemic demands of the academic mental health community. From informal observations to documented presentations, the ethnography surfaced recurring tensions between aspirational discourses of inclusivity and the persistent stratification of access, especially

among early-career researchers, gendered minorities, and participants from low-resource institutions. Reports of burnout, career fragmentation, and internalized inadequacy were not anecdotal but endemic, aligning with the growing body of literature identifying structural violence and epistemic injustice within scientific institutions as major mental health stressors (Mountz et al., 2015; Harrowell et al., 2018; Cramer et al., 2021). In this context, the absence of reliable support tools, whether digital or relational, emerged as a symptom of deeper infrastructural neglect.

From a medical anthropological standpoint, this experience confirmed that any meaningful intervention in researcher mental health must contend not only with the affective and pharmacological dimensions of coping, but with the sociopolitical architecture of knowledge production itself. The potential of expert systems to mitigate clinician variability, support shared decision-making, and uphold human rights in psychiatric practice is well recognized (Musen et al., 2014). Yet, such systems must be trained, maintained, and governed by transparent standards and co-designed with both practitioners and users. This requires moving beyond performative digitalization toward genuinely restorative infrastructures.

The insights from this virtual ethnography will be integrated into the broader EU BEACON initiative, which positions One Health Education and Technology as a systemic vector for societal transformation. By linking the struggles of academic researchers to those of marginalized psychiatric service users, the research reframes mental distress not as an individual pathology but as an expression of institutional failure and social disconnection. In doing so, it affirms the need for intelligent, open-source, ethically managed expert systems, not as replacements for human care, but as protective scaffolds ensuring quality, accountability, and access, particularly in underserved or structurally violent contexts. This work led to the publication of the following paper at the peer reviewed journal MDPI Social Sciences:

3.2.4 FOSTREN COST Action

The European Violence in Psychiatry Research Group (EviPRG), to which the researcher belongs, constitutes one of the longest-standing interdisciplinary networks in Europe devoted to addressing coercion and violence within psychiatric services. Founded in 1997 and composed of clinicians, researchers, legal scholars, and lived-experience experts, the group has developed into a central node for international collaboration on structural, clinical, and ethical reform in mental health. Its sustained focus on reducing harmful practices, such as mechanical restraint, seclusion, and forced medication, has positioned EviPRG as a critical forum for translating human rights commitments into applied service innovations (Bak et al., 2021; Steinert et al., 2022). The network operates through regular international symposia, collaborative publications, and its flagship event, the European Conference on Violence in Clinical Psychiatry, providing a space for cross-national analysis of coercive trends and the dissemination of alternative therapeutic strategies. In continuity with these objectives, the COST Action FOSTREN (CA19133: Fostering and Strengthening Approaches to Reducing Coercion in European Mental Health Services, 2020–2024) was launched to systematically consolidate empirical knowledge and policy momentum across European contexts. FOSTREN's mandate, supported by the European Cooperation in Science and Technology (COST) framework, has been to develop multidisciplinary pathways for minimizing coercive practices, enhancing staff training, promoting participatory approaches, and reforming institutional cultures where such practices remain embedded (FOSTREN, 2021). The action's working groups addressed distinct thematic areas, including the epidemiology of coercion, ethical-legal frameworks, implementation of trauma-informed care, and the creation of metrics for evaluating coercion reduction initiatives. Emphasis was placed on the co-production of knowledge, involving survivor researchers and civil society stakeholders to ensure that reform processes reflect the priorities and protections required by those most affected.

As an active participant in FOSTREN, the researcher engaged in field analysis and institutional ethnography focused on Southern European mental health systems, specifically Spain and Italy, documenting divergences in the normative, clinical, and infrastructural treatment of coercion. Fieldwork revealed the persistence of disciplinary logics within acute psychiatric units, often reinforced by legal ambiguities and professional reluctance to implement non-restrictive alternatives, despite international guidelines and mounting evidence on the long-term iatrogenic effects of coercion (Gooding, 2015; WHO, 2021). My contribution focused on comparative documentation of policy implementation gaps, barriers to shared decision-making, and the socio-legal invisibilization of coercion, particularly in marginalised populations. Data were gathered through participant observation, professional interviews, analysis of legal frameworks, and integration of qualitative findings from national surveys. Involvement in FOSTREN enabled ongoing collaboration with experts involved in drafting national recommendations for coercion reduction. My participation also facilitated engagement with transnational advocacy efforts aimed at the operationalization of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) within psychiatric services (Degener, 2016; Minkowitz, 2006). The evolving collaboration between FOSTREN and EviPRG supports a long-term scientific infrastructure for pursuing non-coercive, rights-based psychiatry, and my research will continue contributing to this joint mission through the EU BEACON initiative and related international consortia. The findings documented in this dissertation reflect not only field-specific results but also the methodological significance of participating in coordinated European actions where knowledge production, political critique, and clinical transformation intersect.

3.2.3.1 Scientific mission to Italy, Trieste WHO excellence center

As part of the FOSTREN COST Action (CA19133), a funded short-term scientific mission was undertaken in 2022 to the World Health Organization Collaborating Centre for Research and Training in Mental Health in Trieste, Italy. This institution, internationally recognized for its leadership in deinstitutionalization and the development of community-based, human rights-oriented mental health care (Mezzina et al., 2018; WHO, 2021), provided a key site for direct observation, documentation, and comparative analysis within the framework of my dissertation on coercion reduction and shared decision-making. The Trieste model, originally grounded in Franco Basaglia's radical rethinking of psychiatry during the 1970s (Foot, 2015; Basaglia, 1987), remains a rare and paradigmatic example of comprehensive mental health reform prioritizing social inclusion, voluntary care, and open-door services. During this one-month residency, the researcher conducted structured field observation, professional dialogue, and desk research across multiple care sites, including the Dipartimento di Salute Mentale and associated community facilities, gaining insight into operational features such as 24/7 accessibility, multidisciplinary teamwork, legal safeguards against involuntary treatment, and relationally centered practice.

To enrich this ethnographic exposure and ensure a broader comparative lens, the Trieste mission was preceded by one month of self-funded participant observation in Lucca, another Italian site involved in national mental health reform efforts. It was followed by active participation in the International Society for Psychological and Social Approaches to Psychosis (ISPS) 2022 conference held in Perugia, which provided access to current international debates on dialogical approaches, the ethics of diagnosis, and user-led research in psychosis care (ISPS, 2022). The combined mission enabled a triangulated perspective on regional implementation challenges, best practices in community psychiatry, and the sociopolitical constraints impeding broader adoption of non-coercive care. These findings, presented within the present thesis, offer empirical grounding for future EU BEACON-supported coordination actions and further integration of rights-based mental health practice into national and transnational policy frameworks.

During the scientific mission to Trieste as part of the FOSTREN COST Action (CA19133), the researcher had the privilege to engage deeply with the historical legacy and present-day enactment of Italy's democratic psychiatry movement. Thanks to the generosity of Dr. Raffaella Pocobello (IRPPS-CNR) and Dr. Tommaso Bonaviglio (World Health Organization Collaborating Centre for Research and Training in Mental Health, Trieste), the researcher was granted access to the mental health services of Trieste, where the researcher shadowed Dr. Bonaviglio across diverse clinical and community care settings for an entire month. This immersive ethnographic experience enabled me to trace the living heritage of the psychiatric reform initiated by Franco Basaglia and his collaborators, a movement that led to the landmark Law 180/1978, the first national legislation in the world to dismantle psychiatric asylums and establish community-based mental health care grounded in civil rights and social reintegration (Del Giudice, 2018; Foot, 2015; Starace et al., 2020).

My engagement included daily fieldwork and contextual archival research, supported by access to historical documentation and the guidance of local professionals and archivists. Through conversations and site visits, the researcher gained insight into the foundational efforts of figures such as Dr. Franco Rotelli, whose vision helped institutionalize the principles of dignity, dialogical

engagement, and open-door policy as clinical standards, rather than aspirational ideals (Rotelli et al., 2013; Mezzina, 2014). Dr. Rotelli's emphasis on transforming not only psychiatric institutions but also the socio-political matrix in which mental health care is embedded offered a profound reframing of psychiatric reform as a project of civic liberation (Rotelli, 2005). This vision continues today through ongoing efforts in Trieste to resist the re-medicalization of social suffering and uphold a humanistic approach to care, despite national and regional pressures toward austerity, privatization, and risk-management logics (Mezzina et al., 2019).

The archival and embodied dimensions of this fieldwork, made possible by the support of the Trieste mental health services and the WHO Centre's practitioners, highlighted the sustainability and fragility of systemic transformation. Learning from the daily practice of clinicians operating in a system devoid of coercive measures such as locked doors, mechanical restraints, or forced hospitalization underscored the viability of rights-based care as both policy and praxis (World Health Organization, 2021; Puras & Gooding, 2019). These findings are particularly relevant to the central thesis of this dissertation: that shared decision-making, trauma-informed care, and community integration are not optional reforms, but structural imperatives grounded in decades of evidence, as shown in the Trieste model and its ongoing, though threatened, implementation.

The Italian psychiatric reform that culminated in Law 180 of 1978, commonly known as the "Basaglia Law", emerged not from administrative policy nor medical consensus, but from a sustained and radical critique of the foundations of institutional psychiatry. At its core stood the intellectual, clinical, and political work of Dr. Franco Basaglia (1924–1980) and Dr. Franca Ongaro Basaglia (1928–2005), whose partnership forged a path toward the abolition of psychiatric asylums and the birth of a community-based model rooted in human rights, social emancipation, and civil dignity (Basaglia, 1968/2013; Ongaro Basaglia, 1979; Foot, 2015). Drawing from phenomenological psychiatry, Foucault's critique of disciplinary institutions, and a deep existential commitment to human freedom, the Basaglias reframed the asylum not as a therapeutic space but as a total institution functioning to segregate, punish, and disown the socially inconvenient, particularly the poor, women, the elderly, and the disabled (Basaglia, 1980; Foucault, 1961/2006; Goffman, 1961). Before the reform, Italian psychiatry was marked by large custodial institutions often located in remote or marginal areas, where coercion, mechanical restraint, long-term segregation, and forced labor were normalized under the guise of care. Asylums like San Giovanni in Trieste and others throughout the country functioned as zones of exception, where the principles of constitutional protection and legal accountability were suspended (Del Giudice, 2018; Tansella, 1986). The psychiatric subject was stripped of civic status, rendered voiceless under biomedical authority, and subjected to systemic degradation without recourse to appeal. The Basaglias' work, initially at Gorizia, and later Trieste, aimed to reverse this dehumanization through a praxis of "negation": a systematic dismantling of the very conditions that enabled institutional violence to reproduce itself under scientific pretense (Basaglia, 1968/2013; Basaglia & Basaglia Ongaro, 1979).

In Trieste, Franco Basaglia assembled a multidisciplinary team committed to opening the doors of the asylum, not merely as a symbolic gesture, but as a structural imperative. They abolished restraints, began community engagement, and created cooperative structures for users to re-enter social and economic life. This movement, though intensely local, resonated nationally and internationally, catalyzing massive mobilizations involving students, workers, unions, legal reformists, and leftist political factions that saw in the psychiatric struggle a broader battle against institutionalized oppression and class-based exclusion (Foot, 2015; Rotelli et al., 2013; Mezzina,

2014). The slogan "La libertà è terapeutica" (Freedom is therapeutic) became a rallying cry across Italy, culminating in the unprecedented parliamentary passage of Law 180, a radical legal act that mandated the closure of psychiatric hospitals and the creation of community mental health centers under the public health system. Following Franco Basaglia's untimely death in 1980, Dr. Franco Rotelli assumed the leadership of the Trieste experience and further developed its institutional imagination. Whereas Basaglia's contribution lay in the ethical deconstruction of the asylum, Rotelli's focus was on constructing new institutional forms that embodied solidarity, openness, and democracy (Rotelli, 1988; Rotelli et al., 2013). He helped shape the Mental Health Department of Trieste into a WHO Collaborating Centre and advanced the principle that services must be integrated into the life of the city, not peripheral or marginal, but embedded within housing, employment, education, and the social fabric itself (Mezzina et al., 2019). Rotelli expanded the notion of cura (care) to include political and social responsibility, thus challenging the professional closure of medicine and calling for new institutional languages rooted in narrative, participation, and reciprocity. The Trieste model under Rotelli's leadership became internationally recognized for eliminating coercive practices, including involuntary hospitalization, mechanical restraint, and forced treatment, and for pioneering relational, dialogical, and rights-based approaches (World Health Organization, 2021). The system's strength resided not only in its clinical orientation but in its deep integration with civil society, municipal governance, and user-led initiatives. However, as repeatedly emphasized during my scientific mission to Trieste and through interviews with Dr. Rotelli's collaborators and the archivist team, this model remains under siege from regressive tendencies in national policy, budgetary pressures, and a rising global shift toward re-medicalization and risk-management paradigms that threaten its foundational ethos (Pocobello & Bonaviglio, fieldnotes 2023; Starace et al., 2020; WHO, 2022).

What the researcher learned through direct exposure to these settings, combined with historical documentation and first-person accounts, is that the Italian democratic psychiatry movement was not merely an isolated national anomaly but a paradigmatic rupture that continues to offer critical insights for contemporary reform globally. It demonstrated that political will, legal frameworks, and ethical commitment can align to produce transformative mental health systems centered on dignity rather than domination. That legacy, rooted in struggle, theory, and practice, continues to shape both the diagnostic and therapeutic horizons of psychiatry today and provides a cornerstone for this thesis's call for renewed responsibility, scientifically sound dialogical care, and an end to institutional violence in all its forms.

The legacy of Franco Rotelli extended well beyond the Italian borders, finding practical and symbolic expression in the internationalization of the Trieste model during the late 20th century. Among the most emblematic actions in this period was the intervention in Leros, a remote Greek island whose psychiatric hospital had become infamous for the inhumane and degrading treatment of its inmates. Known during the fascist era as a site of internment, Leros had housed political dissidents under the Metaxas dictatorship and later the military junta. By the 1980s, it had evolved into a de facto concentration camp for the chronically institutionalized, a secluded enclave of neglect, marked by mass dormitories, naked patients, pervasive sedation, and mechanical restraints (Papageorgiou et al., 2002; Madianos & Christodoulou, 2007; WHO, 2001). The visit to Leros in 1989 by Franco Rotelli and his colleagues from Trieste, including Roberto Mezzina and Giovanni Neri, under the auspices of the World Health Organization and European Commission, marked a pivotal moment in post-war European psychiatry. The Trieste team's direct engagement catalyzed a

radical deinstitutionalization initiative that came to be known as the "Liberation of Leros", an ethically charged effort to dismantle not only the structures but the very logic of long-term custodial care rooted in eugenic, punitive, and authoritarian traditions (Mezzina, 2005; Papageorgiou et al., 2002). The team worked with Greek reformers and local professionals to implement an alternative care model based on the same principles that had guided the Italian reform: community integration, human rights, psychosocial rehabilitation, and democratic participation in care (Tsiantis, 2010; WHO, 2001). This period represents not merely a logistical operation, but an epistemological rupture. The symbolic power of the Leros intervention lay in exposing the continuity between past totalitarian systems and contemporary psychiatric practice.

The grotesque conditions were not aberrations but the result of systemic neglect reinforced by professional silence, political indifference, and biomedical reductionism. Trieste's action restored voice and agency to those rendered invisible. In doing so, it reaffirmed the fundamentally political nature of psychiatry: that it can operate either as a mechanism of exclusion or as a pathway to citizenship (Rotelli et al., 2013; Mezzina et al., 2019). Roberto Mezzina, Rotelli's long-time collaborator and successor as Director of the Mental Health Department of Trieste (2010–2019), was instrumental in consolidating and expanding the transformative legacy of Basaglia and Rotelli. A psychiatrist and public health expert, Mezzina played a central role in advancing rights-based, non-coercive psychiatric practices within the WHO framework and global reform networks (Mezzina, 2014; WHO, 2021). He emphasized "whole systems" approaches that linked housing, employment, peer support, and cultural participation to mental health recovery, thereby operationalizing the notion that health is never merely clinical, it is social, ecological, and fundamentally relational (Mezzina et al., 2019; WHO, 2022).

In my research stay in Trieste, the researcher had the opportunity to meet and learn from both Dr. Mezzina and several members of the original Trieste and Leros teams. Their testimony, practices, and dedication to ethical transformation provided invaluable insight into how paradigm shifts are made actionable, not only as rhetorical declarations but as institutional design and lived relational practice. The researcher am particularly grateful to Dr. Raffaella Pocobello and Dr. Tommaso Bonaviglio for their support during my field mission, and for facilitating access to historical archives and services. My time shadowing Dr. Bonaviglio and engaging with frontline staff at community centers and residential settings affirmed the enduring viability and adaptability of the Trieste model, even amid systemic pressures and political backsliding.

The liberation of Leros was not simply an act of humanitarian intervention; it signaled the transnational applicability of democratic psychiatry and established an enduring benchmark against which ongoing abuses must be judged. Today, Leros stands as both a warning and a promise: that psychiatric institutions can either perpetuate civil death or foster re-entry into meaningful life, depending on the ethical frameworks and political commitments that guide them. For the present dissertation, the Trieste–Leros continuity exemplifies the core themes under examination: the need to confront institutional violence, to restore epistemic justice, and to construct therapeutic systems not based on compliance but on co-creation, mutual recognition, and structural transformation.

Despite the enduring significance of the Trieste model and the transnational dissemination of dialogical, rights-based care, contemporary psychiatry stands at a crossroads. On one hand, there is now a robust foundation of evidence and historical experience affirming the feasibility, effectiveness, and ethical superiority of democratic psychiatric reform. The Open Dialogue

approach, which grew in part from the epistemic and clinical breakthroughs initiated in Trieste, has been formally endorsed by the World Health Organization as a model of person-centered and non-coercive care (World Health Organization, 2021). It has inspired implementation studies across Europe and beyond, showing promise in reducing hospitalization rates, enhancing social recovery, and decreasing reliance on pharmacological interventions (Seikkula et al., 2006; Bergström et al., 2018; Buus et al., 2021). Simultaneously, the institutionalization of community mental health indicators within the Sustainable Development Goals (United Nations, 2015), and the rise of global human rights frameworks such as the UN Convention on the Rights of Persons with Disabilities (CRPD), provide a normative scaffolding for international reform. The alignment of Open Dialogue, democratic psychiatry, and One Health education frameworks represents a converging opportunity for transformative change.

However, these advances are increasingly threatened by a resurgence of regressive tendencies. Across multiple national contexts, including Italy, Spain, and the United Kingdom, there is mounting pressure to recentralize services, re-medicalize distress, and erode the fragile gains of deinstitutionalization under the guise of fiscal austerity, public safety, or evidence-based standardization (Fakhoury & Priebe, 2007; Mezzina et al., 2019; Spandler et al., 2015). The commodification of care through private-sector encroachment, the bureaucratic fixation on quantifiable outcomes, and the algorithmic regulation of health systems undermine relational practices that are inherently slow, complex, and contextually embedded. professional burnout, structural underfunding, and epistemic injustice within academic psychiatry reproduce hierarchies of knowledge that marginalize experiential expertise and social medicine traditions (Fricker, 2007; Russo & Sweeney, 2016; Rose, 2017). While technological infrastructures could democratize care and enable global collaboration, in practice, they often entrench top-down models of compliance and surveillance (Pérez-Cano et al., 2023; Cosgrove et al., 2020).

Thus, the present conjuncture demands not only technical refinement but political clarity. Without deliberate institutional and professional commitment, even the most promising practices risk co-optation or extinction. The momentum gained through decades of democratic reform, from Basaglia and Rotelli to Mezzina and Open Dialogue networks, must now be defended and expanded in response to neoliberal rollback, policy stagnation, and the global mental health crisis exacerbated by inequality, war, climate collapse, and authoritarianism (Patel et al., 2018; WHO, 2022). The task ahead is to institutionalize ethical, participatory, and context-sensitive forms of care without reproducing the bureaucratic pathologies that have historically turned public health into a vehicle for control rather than liberation. Only by anchoring psychiatry in solidarity, ecological realism, and plural epistemologies can we fulfill its emancipatory potential.

Following the culmination of an intensive ethnographic and academic mission in Italy, including the FOSTREN-funded stay in Trieste and participation in the ISPS International Conference in Perugia, the researcher experienced a stark rupture between the ideals promoted in the reformist psychiatric networks and the material reality of professional vulnerability, institutional denial, and unaddressed domestic violence. Despite engagement with leading scholars and practitioners committed to non-coercive, human rights-based care, the surrounding systems failed to acknowledge or respond to escalating signs of interpersonal abuse. Three months of compounding domestic aggression had left the researcher physically and psychologically battered. Yet, this remained largely invisible within academic and professional spaces, demonstrating the disconnect between mental health discourse and the conditions in which those advocating for reform are forced to survive.

The whole ordeal highlights a big contradiction. While live was packed with experts on psychosis recovery, family systems, and trauma-informed dialogue, the very ethos of openness and mutual care did not extend to provide material support or institutional accountability for its own members facing violence, not even cheap accommodation in the city to all, including survivors. Despite the researcher's attempts to disclose the abuse discreetly and responsibly to colleagues and associations abroad, as the professional distance did not allow it to disclose in person, also shame and shyness, the shock and fear, the responses received were minimal, constrained, some with bureaucratic ambiguity, professional risk-aversion, or emotional detachment. Consequently, key opportunities for follow-up, such as attendance at the subsequent FOSTREN meeting in Poland, were missed, not due to lack of interest or engagement, but due to a state of disorientation, isolation, and systemic neglect. The aftermath, marked by confusion, spiritual retreat, and solitary reflection, reflects not only personal suffering but a collective blind spot: the gap between proclaimed care values and actual protective capacities within academia and psychiatry alike. These states, even among professionals trained in better practices, is easily misidentified as a mental health one to be blamed and situated in the victim itself, when it belongs to the abusers destroying the matrix of society around, hurting their closest ones, creating havoc with impunity. To frame the distress of the other as an illness, is the biggest disfavor to health and medical practice itself.

This incident, which became habitual, daily, from bad to worse since then on, as the willful ignorance of those notified -many were, on all systems and offices, services and spheres with duty to care and support, help out- illuminates several recurring patterns in the ethnography of violence and mental health systems. First, professionals advocating for systemic change are not exempt from vulnerability, especially when situated at the intersections of gender-based violence, transnational mobility, precarious employment, and lack of familial or community support. Second, despite rhetorical commitments to dignity and recovery, institutional cultures often default to passivity or non-intervention when colleagues or collaborators signal distress, particularly if the violence occurs in the "private" domestic sphere. Third, the abuser's ability to manipulate legal, social, and institutional narratives further entrenches impunity and delegitimizes the survivor's account, a phenomenon well-documented in feminist, anthropological, and psychiatric literature on gaslighting, testimonial injustice, and structural violence (Stark, 2007; Fricker, 2007; Kelly, 2013; Scheper-Hughes & Bourgois, 2004). Lastly, the embodied consequences of chronic abuse, including somatic dysregulation, impaired concentration, and dissociative coping, are compounded by the professional demands of performance, visibility, and composure in elite scientific environments.

The scientific, ethical, and clinical implications are urgent. Training programs and professional societies must incorporate actionable frameworks for identifying, supporting, and protecting victims of intimate partner violence within their own ranks. These must go beyond lip service and embrace the complexities of intersectional vulnerability, including for migrant scholars and clinicians without institutional shelter. Furthermore, there is a critical need to embed trauma-awareness and safeguarding mechanisms into every level of academic, clinical, and policy infrastructure, not merely as therapeutic tools, but as core ethical obligations. The failure to do so, as this case demonstrates, not only perpetuates harm but corrodes the credibility of mental health reform itself as it stands now, treatment as usual. The implementation of the reforms halted, half way. The data collected through this embodied experience are not anecdotal, they constitute empirical evidence of how even the most enlightened discourses can falter in the face of real-world violence, unless systems of care are mirrored by systems of accountability, solidarity, and protection.

Throughout this research process, it became increasingly evident that systemic cognitive biases and culturally embedded power asymmetries function to shield perpetrators, particularly those embedded within affluent family networks or linked to institutional influence, from accountability for severe interpersonal and structural violence. This dynamic often unfolds through the strategic deployment of psychiatric diagnosis as a tool of discreditation and control, whereby victims of abuse, especially those who are intellectually autonomous, professionally vocal, or publicly visible in non-normative identities, are pathologized to invalidate their testimony. In my own case, the intersection of my status as a researcher, my openly acknowledged intersex condition, and my capacity to articulate, recover, and critique from within a lived experience of violence became triggers for systematic retaliation. Far from receiving protection or due process, the researcher was met with escalating forms of medicalized silencing and institutional complicity: diagnoses used to cover abuse, threats to undermine my work, and persistent efforts to redirect suspicion onto me rather than investigate the aggressors. Such dynamics are congruent with documented patterns of "epistemic exploitation" (Berenstain, 2016), "testimonial injustice" (Fricker, 2007), and "institutional betrayal" (Smith & Freyd, 2014), whereby victims, particularly those who diverge from expected norms of gender, identity, or behavior, are cast as unreliable, unstable, or pathological, rendering them vulnerable to chronic retraumatization and systemic exclusion. The misogynistic assumption that women and mothers cannot be abusive was repeatedly used to protect perpetrators while enabling the ongoing psychological, economic, and reputational destruction of the victim. The psychiatric institutions involved, rather than upholding forensic neutrality or clinical ethics, often acted as enforcers of dominant familial or institutional narratives, aligning with the perpetrators to maintain reputational containment and administrative convenience. This underscores a broader structural failure wherein medical institutions are repurposed as instruments of coercion rather than care, a form of what Foucault (1961/2006) described as "psychiatric sovereignty," legitimizing the invisibilization of abuse through the language of clinical rationality. The consequences are devastating, not only for individual victims, but for the credibility of psychiatric systems which, by failing to investigate and rectify these dynamics, participate in the reproduction of violence under the guise of treatment and concern.

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The testimonial burden placed upon victims of domestic violence, particularly those subjected to compounded structural betrayal, is often so great that disclosure becomes virtually impossible outside of an exceptional context of safety, recognition, and sustained professional listening. In this research, lived experience revealed how systemic barriers to help-seeking are not limited to silence or stigma, but include the overt complicity of institutions in normalizing the violence through diagnostic redirection, kinship-based assumptions, and bureaucratic inertia. The anthropological literature has long identified the perils of culturally rigid kinship schemas (Scheper-Hughes, 1992; Carsten, 2004), which can lead professionals to misidentify safety based on familial proximity rather than actual relational dynamics, thereby enabling continued harm under the presumption of protection. In my case, the very individuals and structures ostensibly assigned to offer safety became vectors of continued endangerment, reinforcing a pattern well-documented in the study of *institutional betrayal* (Smith & Freyd, 2014). Despite repeated pleas and formal reports, the absence of action by social services, health professionals, and forensic actors was not merely a failure of competence, it constituted a structural refusal to recognize a form of violence that did not conform to their pre-existing cognitive biases. These included gendered expectations about perpetrators and victims, a dangerous overreliance on psychiatric labels to obscure patterns of abuse, and a systemic inability to address intersubjective truth when power dynamics distort the perception of credibility. As revealed during my fieldwork in Italy, where the researcher learned of historical cases involving extreme maternal despair leading to filicide during the period of psychiatric lobotomization, contemporary practices continue to pathologize the aftermath of structural abandonment while failing to engage with its root causes. That my ex-spouse's behaviors were extreme, targeted, and prolonged, does not exempt them from accountability; rather, the enduring institutional refusal to intervene, protect, or even properly investigate, reflects a profound epistemic collapse in systems tasked with safeguarding vulnerable lives. The fact that the researcher was never violent, consistently sought peaceful resolution, and acted with proactive responsibility, even while being physically and psychologically attacked, should have sufficed for institutional support. That it did not, and still does not, calls for an urgent reappraisal of professional standards in psychiatry, social services, and forensic practice. The problem is not the absence of good professionals, but the systemic inability or unwillingness to identify and empower them, and the widespread toleration, indeed, normalization, of incompetence, complicity, and neglect as default institutional behavior.

The shadowing period at the Trieste WHO Collaborating Centre for Research and Training in Mental Health, under the supervision of Dr. Tommaso Bonaviglio, constituted one of the most enriching fieldwork experiences of this doctoral research. The institutional ethos, daily practices, and interpersonal culture of the Trieste center offered a rare empirical example of the possibility of

radically non-coercive, human rights-aligned psychiatric care in action. Despite being hosted in what formally remained an in-patient unit, the atmosphere, structure, and operational logic were entirely distinct from conventional psychiatric hospitalization models. Through continuous observation and dialogue, this immersion confirmed the viability of an approach where respect, autonomy, and continuity of care were structurally embedded into the clinical practice, aligning with long-standing WHO recommendations for rights-based mental health systems (World Health Organization, 2021; Mezzina et al., 2019).

As reiterated, this period also revealed the jarring contrast between such progressive institutions and the lived realities of domestic abuse and structural violence experienced concurrently in my personal context. The juxtaposition between this model of care and the ongoing systemic failures elsewhere, where victimization, forced medication, and legal neglect prevail, underscored the urgency of translational implementation and policy reform. Despite being in a center of international excellence, the researcher endured escalating episodes of interpersonal violence, institutional betrayal, and precarity, with no sufficient safeguards activated. These events highlight a central thesis finding: the coexistence of best-practice knowledge and institutional excellence with unresolved systemic complicity in silencing victims, particularly in family-related violence scenarios involving intersectional vulnerabilities (intersex identity, survivor status, and precarious professional standing). These experiences illustrate how trauma, even when acknowledged by elite professionals, remains largely unsupported at the structural level. That the violence was frequently rationalized by others as mental illness or personal deficiency, despite years of recovery work, professional activity, and community contribution, exposes persistent diagnostic overshadowing and cognitive biases in how psychiatric and social care systems respond to victims and perpetrators (Rose, 2018; Smith & Freyd, 2014).

The outcome of this ethnographic engagement is therefore dual: while it evidences the success of dialogical, humane psychiatry at the service delivery level, it also documents the fragility of protective frameworks when embedded in broader sociocultural and institutional environments still marred by impunity, gendered violence, and diagnostic misuse. This fieldwork confirms that even in globally lauded psychiatric systems, the burden of trauma recovery remains heavily individualized, with survivors often lacking the institutional recognition or support needed for sustainable healing and participation. These insights reinforce the need for system-wide accountability mechanisms that align best practices with protective infrastructures across all scales, legal, familial, clinical, and educational. While the observational fieldwork in Trieste demonstrated the feasibility and effectiveness of human rights-based psychiatric practice, my concurrent experience of severe domestic abuse revealed the limits of transnational protective responsiveness. It is crucial to emphasize that these failures did not arise within the Trieste system itself, which remained professionally and ethically commendable throughout. The problem resided squarely in the failure of Spanish institutions to provide real-time protective mechanisms for a professional openly requesting help while engaged abroad on a scientific mission. Despite my documented status as a co-author and contributor to international mental health projects, including the Springer Nature volume coordinated by the FOSTREN COST Action on violence in psychiatry, my direct and urgent appeals to multiple professional colleagues, a designated legal contact, and victim support associations went largely unanswered or resulted in ineffective responses. These were not abstract calls for reform; they were situationally specific, time-sensitive warnings raised from a precarious position abroad while enduring escalating, documented violence.

The failure to act was not due to lack of awareness, nor was it attributable to poor communication. Rather, it exemplifies a systemic absence of protocols for cross-border professional protection, compounded by cultural minimization of male or non-normative victims and procedural inertia even among specialized legal and psychological professionals (Freyd, 2018; Bond, 2020). Despite reaching out to those trained in the field, the researcher encountered the full spectrum of epistemic injustice and institutional betrayal: from disbelief to procedural delays and inaction, aggravated by the bias of assuming that geographical distance equates to diminished urgency or plausibility. In the meantime, the violence intensified, leaving visible bruises and triggering profound psychological and physical consequences, all of which were documented and reported, Yet, systematically ignored or downplayed by services whose legal and ethical duty was precisely to intervene.

This experience highlights a central finding of this dissertation: the decoupling of best-practice psychiatric knowledge from institutional and legal responsiveness in real-time violence scenarios, particularly in international or non-normative contexts. While Trieste embodied the potential of democratic psychiatry, Spain's failure to respond, act, or even acknowledge a situation of escalating intimate partner violence demonstrates that access to care and justice remains contingent not on need, but on visibility, social conformity, and bureaucratic convenience. Such findings are consistent with the literature on systemic neglect of survivor professionals (Smith & Freyd, 2014), the invisibilization of abuse in professional domains (Rottenberg, 2014), and the persistent failure of institutions to act on clearly stated evidence of harm when the victim does not conform to expected demographic or diagnostic profiles. In this sense, the fieldwork paradoxically confirmed both the best of what psychiatric reform can achieve, and the ongoing barriers to protecting those who work for it, even when they are active contributors and direct victims of the failures they seek to prevent.

3.2.3.2 World Psychiatric Association Congress and own seminars hosting

The World Psychiatric Association (WPA), as the principal global umbrella organization for psychiatric societies, has historically played a pivotal role in shaping international mental health discourse, with explicit influence on professional standards, ethical guidelines, and policy trajectories. Over recent years, the WPA has gradually incorporated human rights-based frameworks into its normative discourse, publicly recognizing shared decision-making and patient autonomy as central pillars of ethical psychiatric practice (WPA, 2021). Notably, this aligns with recommendations by the World Health Organization and United Nations agencies to transition away from coercive models and toward consensual, trauma-informed, and person-centered care (World Health Organization, 2021; United Nations, 2022). Within this evolving paradigm, the WPA has acknowledged the need to reduce long-term polypharmacy and actively engage with deprescription strategies, particularly in the context of vulnerable populations such as the elderly, persons with psychosocial disabilities, and those historically exposed to overmedicalization in institutional settings. Nevertheless, the operationalization of these principles remains uneven across national and regional associations, constrained by deeply entrenched biomedical assumptions, legal conservatism, and structural inertia.

Against this backdrop, the researcher presented original work at the WPA Congress, supported in part by the COST Action FOSTREN (CA19133), which generously funded the registration fees required to overcome the prohibitive financial barriers commonly imposed by international

psychiatric conferences. Such funding is not merely logistical, it is a matter of epistemic justice and equitable representation. Without it, researchers from underfunded institutions or marginalized backgrounds, including survivor-researchers, early-career investigators, and those from the Global South, would be structurally excluded from shaping the discourse on psychiatric reform. My contribution, delivered through poster presentations, focused on the ethical, empirical, and anthropological imperatives of shared decision-making and deprescription within mental health systems that still operate largely on paternalistic logics. These results, derived from qualitative survey data and fieldwork, challenge the epistemological closure inherent in chronicity-based pharmacological regimens and highlight emerging best practices in collaborative care planning, narrative-based diagnosis, and non-pharmacological interventions supported by both scientific evidence and lived experience.

In the context of the 23rd World Psychiatric Association (WPA) World Congress of Psychiatry, held in Vienna from 28 September to 1 October 2023, the researcher had the opportunity to present preliminary results from two core components of this doctoral research project: the development of autonomous medication management systems and the role of expert systems in mental health as ethically grounded alternatives to coercive practices. These results were disseminated through a series of academic posters and oral presentations accepted by the scientific committee of the congress, with participation made possible through funding from the FOSTREN COST Action (CA19133) and ReMO (CA19117). This support was critical, given the increasing financial inaccessibility of scientific dissemination channels and the persistent global disparities in research participation due to structural inequality and exclusionary academic gatekeeping practices .

The first presentation, titled *Assessment of Autonomous Medication Management as a Viable Supported Decision-Making System*, summarized empirical data collected through qualitative interviews with healthcare professionals and service users navigating psychiatric medication plans. The findings confirmed widespread dissatisfaction with current psychopharmacological practices, emphasizing the need for patient-centered, flexible, and ethically sound alternatives. Practitioners acknowledged the potential of autonomous systems to alleviate the cognitive and emotional burden on users by promoting tailored medication regimens and reducing medical overreach. Users similarly expressed readiness to engage with such systems, provided they ensured safety, oversight, and personalization. Both groups flagged ethical concerns regarding compliance, data protection, and the continued need for professional accompaniment. These insights strengthen the scientific case for integrating deprescription protocols and adaptive monitoring technologies within a participatory care framework .

The second presentation, *Expert Systems in Mental Health: Preliminary Results Based on Interviews with Programmers, Practitioners, Public Health Administrators, Policy Makers, and Experts by Experience*, extended this inquiry by exploring the feasibility and implications of implementing AI-driven systems in clinical mental health practice. Drawing from interviews across disciplines, the study highlighted how biometric and behavioral data streams, such as heart rate variability, keystroke dynamics, and activity tracking, can inform personalized treatment adjustments and predictive interventions. The research underscored the necessity of embedding algorithmic transparency, clinical interpretability, and cross-sectoral governance into such technological frameworks. These findings are essential as mental health care increasingly intersects with digital health, and the potential for exacerbating epistemic injustice or replicating coercive logics through algorithmic black boxes remains a pressing concern .

Both posters presented at the WPA Congress reflect the convergence of current international psychiatric priorities with this dissertation's core objectives: to eradicate coercion, ensure meaningful patient autonomy, and advance science-based, person-centered systems of care. The congress itself affirmed these directions, with numerous sessions dedicated to shared decision-making, trauma-informed practice, the ethics of psychiatric diagnosis, and the urgent need for systemic reform. The support of FOSTREN was especially meaningful, both symbolically and practically, as this research aligns with its stated mission to reduce coercion and support recovery-oriented, rights-based psychiatry.

The broader context of the WPA's official stance must be noted here. The organization has repeatedly advocated for person-centered care, with recent position papers supporting the inclusion of shared decision-making, respect for autonomy, and the gradual integration of technologies that enhance care without replacing the relational core of psychiatric practice (WPA, 2021). Despite these declarations, the implementation gap remains vast, particularly in lower-resourced settings or those dominated by outdated hierarchical structures. This dissertation thus contributes empirical, interdisciplinary evidence to narrow that gap, building on global best practices and grounded research to develop scalable, ethical solutions for mental health systems worldwide.

This participation exemplified a reciprocal knowledge exchange between reform-oriented professional networks and action-research from within the disciplinary margins. Hosting supplementary seminars alongside the WPA Congress allowed for deeper engagement with transdisciplinary audiences, including clinicians, legal scholars, service users, and policy advocates. These sessions reinforced the need to rethink the very architecture of psychiatric care, moving from control and compliance to dialogue and co-construction. They also emphasized the urgent requirement for international organizations such as the WPA to democratize access to knowledge-sharing platforms, ensuring that funding models, language barriers, and professional hierarchies do not silence those best positioned to propose change. The path forward demands not only institutional declarations but enforceable commitments to justice, transparency, and the lived realities of those systemically excluded from decision-making and Yet, profoundly impacted by it.

The seminars on political abuses of psychiatry, co-funded by the FOSTREN COST Action as well, were initiated as a thematic extension of contributions originally proposed for the 23rd World Congress of Psychiatry in Vienna (WPA 2023). Due to the magnitude of the issue and the overwhelming interest expressed by practitioners, researchers, and survivors, the initiative evolved into a comprehensive international event series held online from early October to November 2023. The decision to extend the format beyond the original WPA setting was grounded in the need for secure and inclusive participation, especially as multiple speakers and contributors had faced direct threats, including death threats to family members and workplace harassment, simply for their willingness to disclose evidence of psychiatric abuse and medical torture. These patterns reflect a persistent and underacknowledged phenomenon in both authoritarian and so-called democratic regimes: the instrumentalization of psychiatric labels, treatments, and institutions to suppress dissent, discredit victims, and maintain power structures (Breggin, 1991; van Voren, 2010; Bloch & Reddaway, 1984).

The seminar series created a protected, peer-supported environment for open testimony and the presentation of active international cases, alongside rigorous scientific analysis and legal context. Participating speakers included psychiatrists, anthropologists, human rights defenders, and survivors from multiple regions, highlighting ongoing abuses in Europe, Latin America, Asia, and

the Middle East. Contributions discussed systemic misdiagnoses, institutional complicity, coerced medication or electroshock, prolonged isolation, and gendered and racialized abuse patterns, all supported by evidence of administrative cover-up or judicial inaction. These findings align with broader literature on psychiatric abuse as a political tool (Foucault, 1973; Szasz, 1961; Amnesty International, 2021), and underscore the need for robust international accountability mechanisms, including independent expert monitoring and survivor-led truth commissions.

As the organizer, the researcher coordinated the academic program, ensuring representation from ongoing case documentation efforts and facilitating interdisciplinary dialogue between fields often siloed, clinical psychiatry, medical anthropology, international law and survivor activism. The outputs of this initiative are now archived as proceedings with detailed case reports, theoretical frameworks, and proposed safeguards for both academic freedom and patient rights.

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

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

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

Introduction

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

Political abuse of psychiatry refers to the deliberate misuse of mental-health diagnoses, treatments, or involuntary detention to punish, silence, or discredit dissenting individuals or groups. Van Voren (2009) explains that it means misuse of psychiatric diagnosis, treatment and detention to obstruct people's fundamental rights. Despite appearances to the contrary, such abuses have never been confined to openly authoritarian systems; even in established democracies there are documented instances of whistle-blowers and critics being stigmatized as mentally ill. Indeed, historical and contemporary reports show that the tension between politics and psychiatry has been global and is an ongoing unresolved problem (van Voren, 2010).

The relatively recent historical record is stark. In Nazi Germany, psychiatrists were complicit in eugenic and punitive policies -a violation of their duty of care- using racist and ideologic criteria to justify locking up, deporting and killing disabled and political others (Narayan, 2013). In the Soviet Union during the Cold War, dissent was pathologized on a massive scale. Soviet psychiatrists proclaimed that critics were mentally ill, since no one would oppose their alleged best system unless insane, and often diagnosed dissidents with Snezhnevsky's made up sluggish schizophrenia diagnosis, a supposed mild form of schizophrenia whose symptoms conveniently included reform delusions or struggle for the truth (van Voren, 2010). Van Voren (2009) notes that in the 1970s-80s

roughly one-third of all political prisoners in the USSR were confined in psychiatric hospitals. These practices sparked international outrage and led to the Soviet psychiatric society's suspension from the World Psychiatric Association in 1983. Other Eastern Bloc states followed suit to a lesser extent: for example, reports indicate that Romania under Ceaușescu systematically labeled hundreds of regime opponents as mentally ill (often for crimes like petitioning the authorities), resulting in mass psychiatric incarceration. Countries such as Cuba also implemented sometimes short-lived programs of detaining dissidents in mental institutions in the late 20th century. Notably, an unusual case in 1990s Netherlands showed that such abuse could occur in a democratic setting as well: a Dutch Defense Ministry official falsified psychiatric diagnoses to silence a social worker, a scheme later overturned by courts. These historical episodes - whether in Nazi Germany, the Soviet bloc, or isolated cases in the West - underscore that psychiatry has been repeatedly corrupted as a tool of political repression (Narayan, 2013).

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

Table 1 - Barriers to Political Abuses of Psychiatry

Domain	Protective Factors	Vulnerabilities When Absent
Legal Safeguards	Independent oversight, enforceable patient rights, access to justice	Arbitrary detention, impunity, unchecked coercion
Ethical Practice	External review boards, whistleblower protection, survivor-led ethics	Collusion, fear of reprisal, normalized violations
Clinical Approach	Shared decision-making, trauma-informed care, consent-based treatment	Forced interventions, disregard for autonomy
Training and Culture	Rights-based education, reflective practice, critical pedagogy	Authoritarianism, biomedical dogma, silencing of dissent
Economic Integrity	Transparent funding, non-profit	Overmedication, neglect, market-

	care models, conflict of interest checks	driven interventions
Community Role	Peer support, advocacy groups, participatory service design	Isolation, stigma, lack of accountability
Public Awareness	Media scrutiny, civic engagement, open reporting channels	Denial, invisibility of harm, politicized psychiatric labels

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

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

Elsewhere in Asia and beyond, cases continue to surface. In Iran, for instance, a Lancet Psychiatry commentary (Wasserman *et al.*, 2023) described how a young student was forcibly hospitalized in Tehran after staging a protest against compulsory hijab laws, despite having no medical diagnosis - an act likened to political repression through psychiatry (World Psychiatric Association, 2025; The Lancet Psychiatry, 2025). Human-rights advocates in the U.S. have also warned of such misuse: historically, racist and political dissent have been pathologized: e.g. antebellum drapetomania for escaping slaves, and mid-20th-century civil-rights activists declared delusional (Edwards-Grossi,

2024). While overt examples in modern American politics are rare, the specter remains. Even well-established democracies have seen whistle-blowers subjected to psychiatric censure (van Voren, 2010). The overall pattern is clear: wherever political power is unchecked, there is incentive to brand opponents as mentally ill.

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

Symposium Presentation

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

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

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

Speaker(s)	Topic Covered	Core Focus
Alejandra Gandolfi	Mental healthcare and discrimination against Moroccan migrants in Spain	Systemic Abuse
Al Galves	Critique of the biomedical model and promotion of holistic mental health care	Systemic Reform, Survivor Advocacy
Cathy Wield	Informed consent and psychiatric detention from a survivor-doctor perspective	Survivor Advocacy, Human Rights
Chris Munt	Survivor testimony on psychiatric violence in the UK	Survivor Advocacy
Dainius Pūras	Human rights and mental health from a UN perspective	Human Rights
David Matas	Psychiatric abuses linked to organ harvesting in China	Human Rights, Legal Frameworks

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

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

Hel Spandler, editor of *Asylum: The Magazine for Democratic Psychiatry*, critically examined systemic coercion within the UK mental health system. Chris Munt, survivor and advocate, shared firsthand accounts of abuses in British psychiatric care, highlighting the normalization of violence. Paola Di Maio, systems scientist, articulated a structural model explaining how coercion infiltrates mental health services through psychological and systemic mechanisms. Edel Granda, activist and advocate for transgender rights, foregrounded the pathologization of gender non-conformity as a key dimension of psychiatric oppression.

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

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

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

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

Mechanisms of Abuse (Psychiatric, Psychological, Social)

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

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

Country	Period	Target Group	Type of Abuse Documented
Soviet Union	1950s–1980s	Political dissidents, human rights activists	Forced hospitalization, chemical restraint, isolation
China	1990s–present	Petitioners, Falun Gong members, dissidents, ethnic minorities	Forced hospitalization, chemical restraint, organ harvesting and trafficking

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

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

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

psychiatric oppression as a form of political and social violence embedded in broader patterns of discrimination and exclusion.

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

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

Thematic Synthesis of Symposium Discussions

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

One central theme was the instrumentalization of psychiatric diagnosis. David Matas, focusing on China’s organ harvesting practices, explained that psychiatric labels are used strategically to delegitimize political and religious dissidents, facilitating both their disappearance and commodification (Matas, 2025). Similarly, Yutong Zhang detailed how psychiatric diagnoses in China are weaponized against petitioners and activists, with forced hospitalization serving as a method of silencing (Zhang, 2025). Another recurring theme was the role of forced treatment and chemical control. Peter Groot’s exposition on tapering strips underscored how psychiatric medication regimens, often initiated under coercion, become chronic mechanisms of control rather than care (Groot, 2025). This point resonated with the broader critique articulated by Chris Munt and Al Galves, who emphasized that in the UK and USA respectively, institutional psychiatry often prioritizes chemical restraint over addressing the underlying social or psychological distress of individuals (Munt, 2025; Galves, 2025).

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

Subterfuge or Foul Play	Method Employed	Path to Extrajudicial Locking	Permissive Factors
Fabrication of mental instability	Spreading rumors, false reports, character assassination	Initiates involuntary psychiatric evaluation without cause	Weak legal standards, corruption in healthcare and law enforcement
Provocation into reactive behavior	Harassment, isolation, threats	Victim’s natural defense misinterpreted as psychiatric symptoms	Institutional bias, failure to investigate impartially

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

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

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

A thread of human rights protection and ongoing reform ran through many contributions as well. Dainius Puras stressed the international human rights framework that obliges states to move toward non-coercive, rights-respecting mental health systems, though he acknowledged the gap between principle and practice remains vast (Puras, 2025). Petr Winkler provided a cautious example of progress, outlining how the Czech Republic has undertaken systemic reforms embedding human rights into psychiatric care, though challenges persist in implementation (Winkler, 2025). It is agreed that addressing the systemic vulnerabilities leading to abuses, medical torture and extrajudicial killings requires more than procedural reforms. Healthcare systems must be reconstructed on principles of strict transparency, due diligence, and external accountability. Every

psychiatric intervention must be independently reviewable, open to audit, and subject to clear, enforceable legal standards. Honest professionals, ethical medical bodies, and judicial systems must coordinate to prevent and punish abuse without exception. Survivors' testimonies must be central to reform. Denial of these realities only perpetuates harm. Recognizing and confronting these abuses directly is essential to building medical and legal systems that protect health, dignity, freedom, and fundamental human rights for all.

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

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

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

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

The weaponization of psychiatry and the manipulation of media narratives operate symbiotically to maintain systemic oppression. Psychiatric institutions, when subordinated to political or social agendas, provide a veneer of medical legitimacy to acts of repression, framing resistance, trauma, or nonconformity as clinical disorders. Media outlets, whether through active propaganda or passive repetition of official narratives, sanitize these abuses, diffusing public outrage and transforming grave violations into mere episodes of private tragedy. This convergence facilitates the erasure of victims' political agency, decontextualizing their suffering and reinforcing hegemonic control. In

environments where dissent is criminalized through medicalization, and where suffering is depoliticized through media framing, the possibilities for justice diminish radically. The challenge, therefore, lies not only in exposing individual abuses but in systematically dismantling the interlocking structures that allow psychiatric authority and mass communication to be deployed as tools of silencing, erasure, and social domination.

Ongoing cases, contemporary patterns and regional examples

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

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

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

changing institutional cultures remains an ongoing challenge (Winkler, 2025). Edel Granda emphasized that psychiatric abuses intersect with other axes of oppression, such as gender identity. She noted that transgender individuals continue to be pathologized in many mental health systems, leading to denial of care, coercion, and social marginalization (Granda, 2025).

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

Building sustainable and principled momentum for reform

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

participate in, and sustain, the political abuse of psychiatry and other forms of institutional violence without critical reflection. Addressing this phenomenon requires dismantling not only abusive laws but the cultural and moral structures that legitimize their application at every social level.

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

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

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

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

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

Reform at the International Level

Strengthen and enforce international legal standards: States should fully implement the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and related treaties. In particular, governments must heed the CRPD Committee's call to ban all non-consensual psychiatric interventions and involuntary hospitalization. International human rights bodies (UN

Special Rapporteurs on health, torture, and disability, the UN Human Rights Council and Universal Periodic Review, etc.) should systematically monitor mental health laws and practices, issuing binding recommendations. Global institutions like the World Health Organization should integrate human rights and trauma-informed care into their mental health guidelines, requiring UN member states to shift resources from coercive institutions to community-based supports. International funding mechanisms (World Health Organization, World Bank, philanthropy) must prioritize alternatives to institutional care and psychosocial rehabilitation, as urged by former UN Rapporteur Dainius Puras.

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

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

Reform at the National Level

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

Dedicated funding and resources: Budgets must shift from custodial hospitals to community supports. Governments should prioritize and fund a spectrum of psychosocial rehabilitation and recovery programs. This includes crisis outreach teams, supported employment, education and housing initiatives. Victims must have rapid access to counseling, legal aid and compensation; funding for victim protection programs should be guaranteed. Transparency in spending is essential to deny misuse of resources by corrupt interests (for example, requiring public reporting of hospital bed occupancy and preventing profiteering from involuntary care).

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

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

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

Reform at the Institutional Level

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

Trauma-informed environment: Facilities should be designed and operated to minimize trauma triggers. This includes quiet spaces, privacy, and options (e.g. single rooms if requested). Staff should receive trauma-awareness training so that simple actions (a calm tone of voice, asking permission before touching) become routine. Every institution needs permanent peer-support workers or counsellors (people with lived experience) available to help victims navigate the system. Models like *Soteria houses* or peer-run crisis centers can be embedded in the health system as alternatives to hospitals - ensuring that voluntary, non-medical recovery options exist.

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

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

Reform at the Community and Civil Society Level

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

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

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

Community-based healing and prevention: Local programs - such as anti-violence initiatives, substance abuse recovery groups, and cultural healing practices - can address the root causes of trauma and distress, reducing demand for coercive psychiatry. Civil society can establish trauma-competent community centers offering free counseling and social support. Partnerships with schools and youth organizations are key to early intervention: educators and parents should learn to recognize distress and engage supportive networks before crises escalate to psychiatric detention.

Reform at the Professional Level

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

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

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

Legal and rights support: On an individual level, victims need clear information about their rights and remedies. All victims should be offered legal counsel to challenge unjust treatment or obtain reparations. Social workers or patient advocates must guide them through any appeals or complaints processes. respecting freedom means acknowledging survivors as experts in their own care - institutions should routinely solicit and implement survivor feedback on services. Throughout all levels, enforcing human rights strictly must be non-negotiable. Any violator - whether a state actor, institution, or individual professional - must be held accountable under the law. By combining top-down legal protections with bottom-up community empowerment and person-centered services, the system can transform from one of coercion to one of healing, dignity and true recovery.

Discussion

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

This permeable environment creates conditions in which abuses occur with alarming ease. Rogue states, corrupt actors, and criminalized systems exploit psychiatric institutions to eliminate dissent, punish the vulnerable, and silence the inconvenient, all under the deceptive pretense of medical care. As highlighted by David Matas, Yutong Zhang, Yanxi Mou, Manuel Llorens, and others,

psychiatry, under these corrupt conditions, serves state terror, private vendettas, and criminal profiteering. This perversion is not an unintended anomaly; it is the direct result of allowing incompetent authority to replace the sane state of mind and sound authority that must underpin any legitimate exercise of power, especially where human vulnerability is concerned.

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

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

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

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

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

At the national level, legislation and policy must not only prohibit psychiatric coercion but foster environments where research into systemic abuses is protected and encouraged. National research councils, ombuds institutions, and independent commissions must actively support interdisciplinary investigations into psychiatric practices, without political or corporate interference. Protection of researchers, whistleblowers, and survivors must be codified in law, recognizing that fear, dismissal, and denial - often fueled by vested interests in the healthcare, pharmaceutical, security, and political

sectors - have historically silenced critical inquiry. Nations must ensure that confronting psychiatric abuses is not treated as destabilizing but as strengthening the social and legal order.

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

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

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

Breaking this cycle demands more than reforms: it requires courage, interdisciplinary solidarity, and the unwavering insistence that human dignity, freedom, and sanity are not negotiable. Only by fortifying research, amplifying survivor leadership, and protecting truth-telling against the reprisals of vested interests can societies reclaim psychiatry as a genuine instrument of healing rather than a

tool of fear and domination. Across all levels, the principles must be uncompromising: do no harm, eradicate coercion, deny criminal misuse, enforce all human rights strictly, and uphold the primacy of human dignity, freedom, and life. Psychiatry must not drift into being an accomplice to repression. It must actively become a guardian of humanity's highest ethical commitments.

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

Table 6: Reclaiming Healing in Psychiatric Care

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

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

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

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

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

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

Conclusion

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

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3.2.3.3 Springer-Nature book

The *Springer Nature* volume titled *Violence in Mental Health Settings: Causes, Consequences, Management, and Prevention* (forthcoming, 2025) emerges from the collaborative efforts of the European Violence in Psychiatry Research Group (EViPRG) and the COST Action FOSTREN (Fostering and Strengthening Approaches to Reducing Coercion in European Mental Health Services). The book, edited by internationally recognized scholars and practitioners, synthesizes critical findings across disciplines to address the persistent problem of violence and coercion in psychiatric contexts. It integrates theoretical frameworks, empirical research, and practice-oriented strategies with the shared objective of contributing to a paradigm shift in mental healthcare systems, moving from reactive, control-based approaches toward evidence-based, participatory, and human rights-aligned practices.

Among the contributions, the chapter co-authored by Dr. Brian Littlechild and Dr. Chris Munt (Munt, 2024), two seasoned researchers in social work, safeguarding, and psychiatric service user experience, focuses on qualitative testimonies and the ethical implications of coercion in mental health care. This chapter, initially planned as a co-authored piece with the author of this dissertation, had to proceed without their direct contribution due to the extreme domestic violence endured during fieldwork in Italy (Trieste, Lucca, and Perugia) while under FOSTREN's funded scientific mission. Despite the professional commitment, the author was forced to withdraw mid-process, though not before gathering preliminary testimonies and ethnographic accounts from psychiatric survivors that were forwarded to the co-authors with proper documentation. This form of testimonial relay, though interrupted by harm, illustrates the structural violence facing even those conducting research on coercion, compounding the urgency of the problem under study.

The author's direct contribution to the book, however, was fulfilled through an independently authored chapter with Dr. Anna Björkdahl (Torrents, 2024). This chapter integrates personal fieldwork, cross-national ethnography, survivor testimonies, and a review of emerging best practices including Open Dialogue, supported decision-making, collaborative medication management, and digital expert systems aligned with trauma-informed care. The analysis is situated within the biocultural and action-research framework guiding this dissertation, emphasizing the intersection between clinical responsibility, epistemic justice, and social accountability. The chapter critiques the dominant psychiatric model that justifies coercive treatment under the logic of

chronicity and assumed dangerousness, often pathologizing both distress and resistance while obscuring systemic causes of suffering such as poverty, gender-based violence, and racial exclusion (Rose et al., 2017; Pūras, 2020).

The chapter also highlights the discrepancy between documented alternatives, many of which have been operationalized for decades in countries such as Italy, Finland, and Brazil, and their insufficient adoption within dominant systems still governed by punitive, custodial, and pharmacologically reductionist paradigms. The analysis calls for a political reframing of psychiatry, moving from risk management to rights-based relational healing, in line with the WHO QualityRights initiative (World Health Organization, 2019) and the UN Convention on the Rights of Persons with Disabilities (CRPD, 2006). The case is made for urgent reinvestment in peer-led services, culturally adapted therapeutic modalities, structural supports such as housing and income, and institutional redesign that prioritizes dignity, safety, and full participation of those affected.

The publication of this volume under Springer Nature, with contributions from over a dozen authors, represents a significant step in consolidating transnational efforts to reduce psychiatric violence and implement sustainable, humane alternatives. The work reinforces the argument of this dissertation: coercion is neither therapeutic nor inevitable. Alternatives exist. They are documented. What is missing is not evidence, but will, political, institutional, and professional.

Alternatives to Coercion

Enric Garcia Torrents and Anna Björkdahl

1 Introduction

Coercion in mental healthcare has been a longstanding issue, with roots tracing back to the early days of institutionalised care. Historically, mental health treatment was often characterised by a paternalistic approach, where healthcare professionals made decisions on behalf of patients, sometimes resorting to forceful and invasive interventions. This approach was largely driven by a perceived need to protect both the individual and society, with the autonomy and dignity of the individual often being overlooked.

Coercion in mental healthcare can take various forms, including involuntary hospitalisation, forced medication and the use of physical restraints or seclusion. These practices have been shown to have profound implications for the autonomy, dignity and well-being of individuals receiving care. The use of coercive practices often results in a significant loss of autonomy for these individuals, which can be detrimental to their recovery process.

Moreover, coercion and violence are intrinsically linked. The imposition of coercive measures often requires some form of violence or force, and the experience of being coerced can lead to violent reactions. This cycle of violence and coercion can exacerbate mental health symptoms and hinder the recovery process. Over the years, there has been a growing recognition of the need for alternatives to coercion in mental healthcare. This shift in perspective has been driven by a number of factors, including advances in our understanding of mental health and recovery,

E. G. Torrents (✉)

Medical Anthropology Research Centre, Universitat Rovira I Virgili, Tarragona, Spain
e-mail: enric.garcia@urv.cat

A. Björkdahl

Centre for Psychiatric Research, Karolinska Institutet, Solna, Sweden
e-mail: anna.bjorkdahl@ki.se

increased awareness of human rights, and the lived experiences of individuals who have been subjected to coercive practices.

In the rest of the chapter, we explore inpatient, community-based and treatment-wide alternatives, aiming to help transform traditional practices. In the inpatient context, alternative methods create therapeutic environments that respect patients' autonomy and comfort. These solutions strive to replace coercive measures with patient-controlled interventions, such as sensory rooms and open door policies, fostering an atmosphere of trust and safety. Community-based alternatives focus on social support and inclusive care. By providing resources like recovery colleges and peer support services, individuals are empowered to actively engage in their journey to mental well-being. Treatment-wide alternatives promote patient agency and active participation in decision-making processes. These approaches foster collaborative communication between patients and healthcare providers, ensuring that treatment plans align with individual preferences and needs.

To end with, we provide real-world examples to underscore the effectiveness of these alternatives, while emphasising the importance of cultural and socioeconomic factors in shaping mental healthcare practices. By showcasing how alternatives can be put into practice, this chapter aims to inspire transformative changes, promoting compassionate and patient-centred mental healthcare worldwide.

2 Need for Alternatives

Coercion in mental healthcare is a complex and multifaceted issue with profound implications for the autonomy, dignity, and well-being of individuals receiving care (Golay et al., 2019). The use of coercive practices often results in a significant loss of autonomy for these individuals, which, according to numerous studies, can be detrimental to their recovery process (Chieze et al., 2019). Autonomy, the capacity to make informed, uncoerced decisions about one's own life and well-being, is a fundamental human right. It is particularly crucial in healthcare settings, where individuals should have the right to make informed decisions about their treatment and care (Puras & Gooding, 2019).

However, in many mental healthcare settings, the choices and decisions of individuals are often overridden by healthcare professionals (Chapman et al., 2020). Research has shown that this can lead to a sense of disempowerment and helplessness, which can exacerbate mental health symptoms and hinder the recovery process (Cusack et al., 2018; Herrman et al., 2022). The individual's sense of self-efficacy and control over their own life can be undermined, potentially leading to feelings of hopelessness and despair. This is particularly concerning given that a sense of self-efficacy and control is often a key factor in recovery from mental health conditions (Sashidharan et al., 2019). Moreover, the use of coercion in mental healthcare can lead to stigmatisation and labelling, further compounding the challenges faced by individuals with mental health conditions (Steiger et al., 2023). Societal stigma and discrimination are significant barriers to recovery and social inclusion for these individuals (Tyerman et al., 2021). When individuals are

subjected to coercion, they can be labelled and stereotyped, further marginalising them within society.

This can lead to social isolation, reduced opportunities and poorer mental health outcomes (Puras, 2022). The individual's identity can become defined by their mental health condition and their experiences of coercion, rather than their strengths, abilities and potential (Mckeown et al., 2019).

Coercive practices can also cause significant psychological distress. Being subjected to such practices can lead to increased anxiety and depression, and a heightened sense of helplessness and fear (Verbeke et al., 2019). This can be particularly harmful for individuals with a history of trauma (Torrents, 2022). Coercive practices can potentially re-traumatise these individuals, triggering past traumas and exacerbating their mental health symptoms (Hennessy et al., 2023). This highlights the importance of trauma-informed care, which recognises and responds to the effects of trauma, in mental healthcare settings (Hennessy et al., 2023). Trauma-informed care emphasises physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment (Sweeney et al., 2018).

Trust is a cornerstone of any therapeutic relationship, and yet, coercive practices can severely damage the trust between mental health professionals and individuals receiving care. When individuals are subjected to coercion, they may feel betrayed and violated (Bolsinger et al., 2020). This can make it difficult to establish a therapeutic alliance, a collaborative partnership that is often a key factor in successful mental health treatment. The individual may become wary of mental health professionals and services, potentially leading to disengagement from care and poorer mental health outcomes (Hachtel et al., 2019).

Therefore, it is essential to find alternatives to coercion that respect individuals' autonomy, dignity and rights, and promote their recovery and social inclusion (Moro et al., 2022). This includes promoting shared decision-making, where individuals and healthcare professionals collaborate to make decisions about care. Shared decision-making respects the individual's autonomy and expertise in their own life and experiences, and can help to build trust and a therapeutic alliance (Zinkler & von Peter, 2019). It also includes implementing trauma-informed care, which can help prevent re-traumatisation and promote safety and empowerment (Mihelicova et al., 2018). Finally, it includes challenging stigma and discrimination, both within mental healthcare settings and in society more broadly, to promote social inclusion and opportunities for individuals with mental health conditions (Perers et al., 2022).

3 Inpatient Alternative Approaches

Inpatient settings, such as hospitals or clinics, often present unique challenges in the field of mental health care. Individuals admitted to these settings are frequently in the midst of a severe crisis, experiencing high levels of distress and potentially exhibiting violent behaviour. These circumstances can lead to an increased reliance on coercive measures, such as physical restraints or forced medication, in an attempt

to manage the situation. However, such practices can exacerbate feelings of distress and powerlessness, potentially hindering the recovery process.

Recognising these challenges, this section explores innovative inpatient alternatives that aim to transform the traditional approach to mental health care within these settings. These alternatives, which include sensory rooms, open doors policy, AD and patient-controlled admissions, are designed to reduce coercion, promote autonomy and dignity and facilitate recovery even in the midst of a crisis. Each of these alternatives offers unique strategies to navigate the complexities of inpatient care, providing more humane, compassionate and effective treatment options. In the following subsections, we will delve into each of these inpatient alternatives in detail, discussing their principles, methods and the evidence supporting their effectiveness.

Moreover, we will examine the challenges and opportunities associated with implementing these alternatives, providing a comprehensive overview of the current landscape of inpatient mental health care. By exploring these inpatient alternatives, we aim to shed light on the potential of these approaches to transform the inpatient experience, reduce coercion and promote the well-being of individuals with mental health issues, even in the most challenging circumstances.

3.1 Sensory Rooms

Sensory rooms (SRs), also known as multisensory environments, are therapeutic spaces designed to stimulate or soothe the senses. They provide a calming and safe environment for individuals experiencing mental health crises. These rooms are an innovative approach to mental health care, offering a non-pharmacological method for managing distress and promoting relaxation.

The concept of sensory rooms originated in the Netherlands in the 1970s, initially designed for individuals with intellectual disabilities. Recognising the broader therapeutic potential of sensory rooms, they have since been adapted for use in various mental health settings, including hospitals, clinics and community centres across the globe (Brown et al., 2019).

SRs are equipped with a variety of sensory tools, such as soft lighting, calming music, comfortable furniture and tactile objects. The goal is to create an environment that can be tailored to the unique sensory needs of each individual, whether that involves stimulating the senses, soothing the senses or a combination of both. Individuals are encouraged to explore the room and use the sensory tools in ways that are comforting and calming to them. This could involve listening to calming music, watching a lava lamp, feeling the texture of a weighted blanket or smelling a favourite scent. The focus is on promoting a sense of safety, comfort and control, reducing distress and promoting relaxation (Alvarsson et al., 2010). SRs can significantly reduce coercion in mental health care. By providing a calming and soothing environment, SRs can help individuals manage distress and prevent crises, reducing the need for coercive interventions such as seclusion and restraint (Hirsch & Steinert, 2019). This can have a profound

impact on the individual's well-being, promoting a sense of calm, comfort and recovery (Hedlund Lindberg et al., 2019).

Research has shown that SRs can reduce distress, aggression and self-harm, and increase feelings of calm and relaxation (Björkdahl et al., 2016). Individuals report feeling more in control of their emotions and more able to cope with stress and distress (Grinde & Grindal Patil, 2009). Staff members report a decrease in the use of coercive interventions and an improvement in the therapeutic environment (Haig & Hallett, 2023). Despite these promising results, further research is needed to fully understand the effectiveness of SRs across different settings and populations, and to establish best practices for their implementation.

3.2 Open Doors Policy

The open doors policy signifies a paradigm shift in mental health care, underpinned by the principles of transparency, openness and a deep respect for patient autonomy. This policy advocates for the doors of mental health facilities to remain unlocked as much as possible, marking a substantial deviation from traditional practices that often involve containment and control (Hochstrasser et al., 2018a). The inception of the open doors policy was a response to the mounting concerns about the prevalent use of coercion in mental health care, especially the practices of seclusion and restraint. These methods, which typically involve confining individuals in locked rooms or physically restraining them, have been widely criticised for violating individuals' rights and dignity (Kowalinski et al., 2019). The open doors policy introduces an alternative approach that upholds individuals' autonomy and freedom of movement (Steinert et al., 2019).

Implementing an open doors policy necessitates a cultural and procedural transformation within mental health facilities. Rather than relying on locked doors and physical barriers to manage behaviour and avert crises, facilities that adopt this policy concentrate on fostering positive relationships, enhancing communication and cultivating a therapeutic environment (Compton et al., 2023). Staff members receive training in de-escalation techniques and conflict resolution, equipping them to handle crises without resorting to coercion (Gather et al., 2019).

Transparency is a cornerstone of the open doors policy. Individuals are kept informed about the policy and its implications for their care. They are encouraged to move freely within the facility and participate actively in decision-making processes related to their care. This level of openness and transparency can engender trust and foster collaboration between individuals and staff members, thereby promoting a therapeutic environment that is less coercive (Hochstrasser et al., 2018b).

By championing freedom of movement and respect for patient autonomy, this policy can diminish the use of seclusion, restraint and other coercive interventions. This can profoundly impact individuals' well-being, fostering a sense of autonomy, dignity and recovery (Kowalinski et al., 2019). Facilities that have adopted this policy have reported a decrease in the use of seclusion and restraint, a reduction in violent incidents and an enhancement in the therapeutic environment. Individuals

have reported feeling more respected and empowered, while staff members have noted a more positive and collaborative working environment (Steinert et al., 2019), pointing to the fact that the open doors policy can significantly curtail the use of coercion in mental health care.

3.3 Advance Directives and Informed Consent

Advance Directives (ADs) are legal instruments that allow individuals to express their preferences for future mental health treatment in the event they become unable to make decisions for themselves. This innovative approach to mental health care is rooted in the principles of autonomy, self-determination and respect for individual rights (Tinland et al., 2022).

The implementation of ADs involves a formal process in which individuals express their treatment preferences in a written document (Campbell & Kisely, 2009). This document may include preferences regarding medication, hospitalisation, use of seclusion or restraint and other aspects of care. The document also typically designates a trusted person to make decisions on the individual's behalf if they become unable to do so. The AD is then shared with the individual's mental health care provider and becomes part of their medical record. Informed consent is a critical component of ADs. It ensures that individuals are fully aware of the potential risks and benefits of their chosen treatment options and that they have the opportunity to ask questions and receive satisfactory answers before making a decision.

This process respects the individual's autonomy and right to make informed decisions about their care (Murray & Wortzel, 2019). ADs and informed consent reduce coercion in mental health care by giving individuals control over their future treatment. Studies have shown that these practices can reduce the use of coercive measures, improve patient satisfaction and enhance the therapeutic alliance between patients and mental health professionals (Barbui et al., 2021). Patients often report feeling more respected, and mental health professionals report a more collaborative and trusting therapeutic relationship (Braun et al., 2023), thus proving to be an essential intervention in the reduction of coercive measures.

3.4 Patient-Controlled Admissions

Patient-controlled admissions (PCAs) are a progressive approach in mental health care that empowers patients by placing the decision-making authority regarding hospital admission directly in their hands. This approach is firmly rooted in the principle of patient autonomy, recognising that individuals with mental health issues are often the best judges of their own mental health needs (Lindkvist et al., 2019). PCAs represent a significant shift in power dynamics, giving patients the authority to decide when hospitalisation is necessary. This approach necessitates a high level of trust and collaboration between patients and mental health professionals, fostering a more equitable and respectful therapeutic relationship (Olsø et al., 2016).

The implementation of a PCA involves a formal agreement between the patient and the mental health care provider. Under this agreement, the patient has the right to admit themselves to the hospital or clinic when they feel it's necessary, without the need for a professional's approval. The duration of the stay is also typically decided by the patient, within certain agreed-upon limits. This approach respects the patient's autonomy and self-knowledge, while also ensuring that the hospital resources are used responsibly (Ellegaard et al., 2017). By giving patients control over their admissions, this approach can prevent crises and reduce the need for involuntary hospitalisation (Strand & von Hausswolff-Juhlin, 2015). This can have a profound impact on the patient's well-being, promoting a sense of autonomy, control and recovery (Smitmanis-Lyle et al., 2022).

Studies have shown that PCAs have the potential to reduce the number of involuntary admissions, improve patient satisfaction and enhance the therapeutic alliance between patients and mental health professionals (Thomsen et al., 2018). Patients report feeling more respected and empowered, and mental health professionals report a more collaborative and trusting therapeutic relationship (Skott et al., 2021), showcasing the potential impact of PCA on reducing coercion in mental health care.

3.5 Comparative Overview of Inpatient Alternatives

The above-described alternatives to coercion in mental health inpatient settings represent promising interventions to reduce the use of coercive practices. A common factor is the promotion of different aspects of patient autonomy and person-centred care. At the same time, they may not be suitable for all patients and could present challenges to clinical implementation. It is also important to realise that the interventions are supported by different levels of evidence. An overview of the advantages, disadvantages and evidence in support of the interventions is shown in Table 1.

4 Community Alternatives

This section delves into the realm of community alternatives, which are innovative approaches to mental health care that are implemented outside of traditional inpatient settings. These alternatives are rooted in the belief that mental health care should be integrated into the community, promoting social inclusion, autonomy and recovery.

Community alternatives encompass a wide range of interventions, from Recovery Colleges and Peer Support Services to Crisis Intervention Teams and Soteria and respite houses. Each of these alternatives offers unique strategies to reduce coercion in mental health care, providing more humane, compassionate and effective treatment options.

Table 1 Comparative overview of inpatient alternatives

Intervention	Advantages	Disadvantages	Support by evidence
Sensory rooms	Provides a calming environment	Requires resources to set up and maintain	Emerging: Early studies show promise, the body of research is still growing
	Non-pharmacological method for managing distress	May not be suitable for all patients	
Open doors policy	Promotes freedom and autonomy	Requires staff training to manage potential risks	Mixed: Some studies show reduced use of seclusion and restraint, yet results vary across different settings
	Can reduce feelings of confinement and distress	May not be suitable for all settings or patients	
Advance directives	Respects patient’s preferences and autonomy	Requires patient to anticipate future needs and preferences	Established: Numerous studies support the use of AD, although implementation can be challenging
	Can guide care during crises when the patient may be unable to communicate preferences	May be difficult to implement if patient’s condition changes rapidly	
Patient-controlled admissions	Gives patients’ control over the admission process	Requires resources and flexible bed management	Preliminary: Initial studies show reduced hospital stays and improved patient satisfaction, further research is needed to confirm findings
	Can prevent crises and reduce involuntary admissions	May not be suitable for all patients or situations	

In the following subsections, we will explore each of these community alternatives in detail, discussing their principles, methods and the evidence supporting their effectiveness. We will also examine the challenges and opportunities associated with implementing these alternatives, providing a comprehensive overview of the current landscape of community-based mental health care.

By exploring these community alternatives, we aim to shed light on the potential of community-based approaches to transform mental health care, reduce coercion and promote the well-being of individuals with mental health issues.

4.1 Recovery Colleges

Recovery colleges represent an innovative approach to mental health care, grounded in the principles of education, co-production and empowerment. These institutions provide a range of courses about mental health and recovery, designed and delivered collaboratively by individuals with lived experience of mental health issues and mental health professionals (Repper et al., 2022).

The concept of recovery colleges originated in the United Kingdom in the early twenty-first century, as part of the broader recovery movement in mental health care. This movement recognised the value of education as a powerful tool for recovery, and the unique insights and knowledge that individuals with lived experience can bring to the educational process (Thériault et al., 2020).

Recovery colleges operate on several key principles. Firstly, they embrace the concept of co-production, with courses being jointly designed and delivered by individuals with lived experience and mental health professionals. This collaborative approach fosters a sense of equality and mutual respect, and ensures that the courses are relevant, practical and grounded in real-life experiences (Bourne et al., 2018). Secondly, recovery colleges offer a diverse range of courses, covering topics such as understanding mental health issues, coping strategies and principles of recovery. This diversity ensures that individuals can find courses that are relevant to their needs and interests, and that they can continue to learn and grow throughout their recovery journey. Thirdly, recovery colleges are open to anyone interested in learning about mental health and recovery. This includes individuals with mental health issues, their families and friends, and mental health professionals. This inclusivity fosters a sense of community and mutual understanding, and helps to break down barriers and stigma associated with mental health (Crowther et al., 2019).

The implementation of recovery colleges can significantly reduce coercion in mental health care. By promoting education and empowerment, these institutions enable individuals to take control of their mental health and recovery, reducing the need for coercive interventions. This can have a profound impact on individuals' well-being, fostering a sense of empowerment, hope and recovery (Thériault et al., 2020).

As of the current date, there are over 100 recovery colleges worldwide, with the majority located in the United Kingdom, Australia and Canada. These institutions vary in size and scope, but all share a commitment to the principles of co-production, education and empowerment. The operation of these colleges typically involves a team of staff members, including coordinators, educators and peer support workers, who work together to develop and deliver the courses. Funding for these colleges often comes from a combination of government funding, grants and course fees (Repper et al., 2022).

Research has shown that recovery colleges can have a positive impact on individuals' mental health and well-being. Participants report increased knowledge and understanding of mental health, improved self-confidence and self-efficacy, and enhanced hope and optimism about the future. However, further research is needed to fully understand the impact of these colleges on individuals' mental health outcomes and experiences, and to identify best practices for their implementation (Hayes et al., 2023). By fostering a sense of empowerment, hope and recovery, these institutions can play a crucial role in transforming mental health care and reducing coercion.

4.2 Peer Support Services

Peer support services represent a transformative approach in mental health care, predicated on the mutual exchange of experiences and knowledge between individuals who have encountered similar mental health challenges. This paradigm shift towards peer-led support has been instrumental in fostering a sense of community, empowerment and recovery among individuals navigating their mental health journeys (Shalaby & Agyapong, 2020).

The genesis of peer support lies in the consumer/survivor/ex-patient (C/S/X) movement that emerged in the 1970s and 1980s. This movement was a response to the often dehumanising and coercive practices of traditional mental health care. Advocates of the movement sought to challenge these practices and promote alternatives that respect individuals' autonomy, dignity and lived experiences (Ibrahim et al., 2020). Peer support services are grounded in the principles of empathy, mutual aid and experiential knowledge. Peer supporters are individuals who have lived experience of mental health conditions and recovery, and who have received training to support others on their recovery journey. They offer a unique perspective, understanding and empathy that can be profoundly validating and empowering for those they support (Kinane et al., 2022).

The role of peer supporters is multifaceted. They provide emotional support, share coping strategies, offer practical advice and advocate for individuals within the mental health system. They also serve as role models, demonstrating that recovery is possible and inspiring hope. Importantly, peer support is based on mutual respect and equality, with the peer supporter and the individual they support learning and growing together (Easter et al., 2021). Peer support services can be provided in various settings, including mental health services, community organisations and online platforms. They can take various forms, including one-on-one support, group support, peer-run services and peer-led education and advocacy initiatives. The flexibility and diversity of peer support services make them accessible and relevant to a wide range of individuals (Kent, 2019). Implementing peer support services requires a shift in the traditional power dynamics of mental health care. It involves recognising and valuing the expertise of lived experience and creating spaces where this expertise can be shared and honoured. It also requires resources and training to ensure that peer supporters are supported in their role and that the services are safe and effective (Sanchez-Moscona & Eiroa-Orosa, 2021).

Despite these challenges, the benefits of peer support services are significant. Research has shown that they can reduce the use of coercive measures, enhance patient satisfaction and improve mental health outcomes. They can also promote a sense of empowerment and self-efficacy, which are key factors in recovery from mental health conditions (Johnson & Rogers, 2020), offering a supportive and empowering approach that respects the individual's autonomy and lived experiences.

4.3 Crisis Intervention Teams

Crisis Intervention Teams (CITs) represent a community-based approach to mental health crises, offering an alternative to traditional law enforcement responses. These teams consist of specially trained police officers who collaborate with mental health professionals and community agencies to provide a compassionate, effective response to individuals experiencing mental health crises (Marcus & Stergiopoulos, 2022). The CIT model was first developed in Memphis, Tennessee, in the 1980s, in response to a tragic incident where a man experiencing a mental health crisis was fatally shot by police. The model has since been adopted by many law enforcement agencies across the United States and internationally, reflecting a growing recognition of the need for a more humane and effective response to mental health crises (Rogers et al., 2019).

The primary goal of CITs is to ensure the safety and well-being of all involved parties during a mental health crisis. CIT officers receive specialised training in recognising and understanding mental health conditions, de-escalation techniques and crisis intervention strategies. They work closely with mental health professionals and community agencies to connect individuals with appropriate services and support, aiming to divert them from the criminal justice system whenever possible (Kane et al., 2018).

CITs also play a crucial role in reducing stigma and improving community relations. By promoting understanding and compassion towards individuals with mental health conditions, CITs can help to challenge negative stereotypes and foster a more inclusive and supportive community environment (Hogan & Goldman, 2021). However, the implementation of CITs is not without its challenges. It requires a significant investment in training and resources, as well as a strong commitment from law enforcement agencies, mental health services and the community. It also requires a shift in attitudes and practices, moving away from a punitive approach towards a more compassionate and supportive response to mental health crises (Haigh et al., 2020).

Despite these challenges, the benefits of CITs are significant. Research has shown that CITs can reduce the use of force, improve officer safety and increase access to mental health services. They can also reduce the criminalisation of individuals with mental health conditions, promoting a more just and humane approach to mental health crises (Marcus & Stergiopoulos, 2022). By promoting safety, compassion and access to services, CITs can transform the way our communities respond to mental health crises.

4.4 Soteria and Respite Houses

Soteria and respite houses represent a community-based alternative to traditional mental healthcare, providing a supportive and non-coercive environment for individuals experiencing mental health crises. These facilities are grounded in the

principles of respect, empowerment and recovery, offering a transformative approach to mental health care (Friedlander et al., 2022).

The Soteria model was first developed in the 1970s by psychiatrist Loren Mosher as a response to the often coercive and institutional nature of mental healthcare. Soteria houses provide a residential setting where individuals experiencing acute mental health crises, particularly those with psychosis, can live and receive support from a team of non-professional staff. The focus is on creating a therapeutic environment that respects the individual's experience and autonomy, rather than relying on medication and coercion (Croft et al., 2021). Respite houses, on the other hand, offer a temporary place of refuge for individuals experiencing mental health crises. They provide a calm and supportive environment where individuals can take a break from their usual surroundings, receive peer support and develop coping strategies. Respite houses aim to prevent the escalation of crises and reduce the need for hospitalisation, promoting recovery and autonomy (Cooper et al., 2021).

Both Soteria and respite houses emphasise the importance of a supportive and understanding community in facilitating recovery. They provide a space where individuals can explore their experiences, develop self-understanding and build resilience. The focus is on the individual's strengths and potential, rather than their symptoms or diagnosis (Calton et al., 2008). However, implementing the Soteria and respite house models is not without its challenges. It requires a shift in the traditional power dynamics of mental healthcare, with non-professional staff and peers taking on significant roles. It also requires resources and training to ensure that staff can provide appropriate support and manage potential risks. Furthermore, these models may not be suitable for all individuals or situations, and further research is needed to understand how they can be most effectively implemented (Nischk & Rusch, 2019).

Despite these challenges, the benefits of Soteria and respite houses are significant. Research has shown that they can reduce the use of coercive measures, enhance patient satisfaction and improve mental health outcomes. They can also promote a sense of empowerment and self-efficacy, which are key factors in recovery from mental health conditions (Stupak & Dobroczyński, 2019), representing a promising alternative to traditional mental healthcare, offering a supportive and non-coercive approach that respects the individual's autonomy and promotes their recovery.

4.5 Comparative Overview of Community Alternatives

The described alternatives are implemented outside of inpatient settings and promote mental health care integration into the community, social inclusion, autonomy and recovery. Similarly to inpatient alternatives to coercive practices, these interventions may not be suitable for all persons and some require substantial resources from the community. Table 2 shows an overview of the advantages, disadvantages and evidence in support of the community alternatives.

Table 2 Comparative overview of community alternatives

Intervention	Advantages	Disadvantages	Support by evidence
Recovery colleges	Provides education and skills training	Requires resources and staffing	Established: Numerous studies show improved self-management skills and recovery outcomes
	Promotes self-management and recovery	Effectiveness may depend on curriculum and teaching quality	
Peer support services	Provides support from someone with lived experience	Requires careful recruitment and training	High: A substantial body of research supports the effectiveness of peer support services
	Can reduce feelings of isolation	Role and responsibilities need to be clearly defined	
Crisis intervention teams	Provides immediate, intensive support	Requires significant resources and staffing	Mixed: While some studies show reduced hospital admissions and improved patient satisfaction, results vary across different settings and populations
	Can prevent hospitalisation	May not be available in all areas	
	Promotes dialogue		
Soteria and respite houses	Provides a non-medical, home-like environment	Requires resources to maintain	Emerging: Early studies show promise, particularly in reducing hospitalisation rates and improving quality of life, but more research is needed
	Can provide respite for individuals and families	May not be suitable for individuals with severe symptoms	

5 Treatment-Wide Alternatives

This section explores treatment-wide alternatives, which are innovative approaches to mental health care that can be applied across various settings, from inpatient to community-based environments:

5.1 Shared and Supported Decision-Making

Shared decision-making has its roots in the patient-centred care movement, which emerged in the 1950s, advocating for the active involvement of patients in their healthcare. Historically, mental healthcare was characterised by a paternalistic approach, where healthcare professionals made decisions on behalf of patients, sometimes resorting to forceful and invasive interventions. This approach was largely driven by a perceived need to protect both the individual and society, often overlooking the autonomy and dignity of the individual (Duffy et al., 2023).

However, over the years, there has been a paradigm shift towards shared and supported decision-making, a cornerstone of patient-centred care. This approach fosters a collaborative relationship between patients and healthcare providers,

respecting the autonomy of the patient, acknowledging their unique insights into their own experiences and needs, and actively involving them in the decision-making process. This is particularly crucial in mental healthcare, where decisions can have profound implications for the patient's autonomy, dignity and well-being (Drake et al., 2022).

Shared decision-making can empower patients, enhancing their sense of control over their own lives and their healthcare journey. This can contribute to a sense of self-efficacy, which is often a key factor in recovery from mental health conditions (Hughes et al., 2018). By fostering a sense of partnership and trust, shared decision-making can also enhance the therapeutic alliance, a collaborative partnership that is often a key factor in successful mental health treatment (del Barrio et al., 2013).

Supported decision-making goes a step further, providing additional support to individuals who may have difficulty making decisions due to their mental health condition. This can involve a trusted person who helps the individual understand their options and make decisions, or structured decision-making tools that guide the individual through the decision-making process (Burns & Rose, 2013). However, shared and supported decision-making is not without its challenges. It requires a shift in power dynamics, with healthcare professionals needing to relinquish some of their traditional authority and control. It also requires resources and training to implement effectively, and may not be suitable for all patients or situations (Knight et al., 2018).

Despite these challenges, the benefits of shared and supported decision-making are significant. Research has shown that it can enhance patient satisfaction, improve treatment adherence and lead to better health outcomes (Penzenstadler et al., 2020). It can also reduce the use of coercion in mental healthcare, promoting a more respectful and dignified approach to care (Stone et al., 2020). Further research is needed to understand how to implement this approach effectively in different contexts and to evaluate its impact on patient outcomes and experiences (Sugiura et al., 2020).

5.2 Open Dialogue Teams

Open Dialogue (OD) is a transformative approach to mental health care that originated in Western Lapland, Finland, in the 1980s. OD teams represent a transformative approach to mental health care, focusing on fostering open, respectful and inclusive communication between individuals with mental health issues, their families and mental health professionals. OD has garnered significant attention for its emphasis on dialogical communication and its potential to reduce coercion in mental health treatment. The approach emerged as a response to the limitations of traditional mental health care, which often relied on individualised treatment plans and medical authority (Alakare & Seikkula, 2021). OD seeks to create a more inclusive and dialogical approach to mental health treatment, emphasising the importance of involving patients and their support networks in the decision-making process ((Olson et al., 2014). The key principles of OD include:

- **Immediate response:** The team responds to a mental health crisis as soon as possible, often within 24 h. This immediate response is crucial in building a therapeutic alliance and preventing unnecessary hospitalisation.
- **Social network perspective:** OD involves a network of professionals, including mental health nurses, psychiatrists, psychologists and social workers, working together with the patient and their social network. This approach acknowledges that mental health issues are embedded in social contexts and require a holistic response.
- **Flexibility and mobility:** The OD team is flexible and mobile, meeting in places where the patient feels most comfortable. This could be at home, in a community centre or a hospital.
- **Continuity:** The same team is responsible for the entire treatment process, from the initial crisis to outpatient care. This continuity of care is essential in building trust and understanding.

The implementation of OD involves several core principles and practices:

- **First contact:** When a person experiences a mental health crisis, a team, including mental health nurses, immediately responds and initiates contact. This rapid response is crucial for building a therapeutic alliance and preventing unnecessary hospitalisation.
- **Multifamily meetings:** Multifamily meetings form the core of OD. These meetings involve the patient, their family, friends and other relevant individuals, coming together with the treatment team to discuss the crisis and potential solutions.
- **Open communication:** Participants are encouraged to express their perspectives openly and respectfully. Mental health nurses facilitate the dialogue, ensuring that everyone's voice is heard and valued.
- **Network approach:** OD involves a network of professionals, including mental health nurses, psychiatrists, psychologists, and social workers, working together with the patient and their social network. This approach acknowledges that mental health issues are embedded in social contexts and require a holistic response.
- **Flexibility in treatment planning:** Treatment plans are not predetermined; instead, they emerge from the ongoing dialogue during the multifamily meetings. The focus is on finding a solution that aligns with the patient's preferences and social context.

Implementing OD requires a shift in the traditional hierarchical relationship between patients and healthcare providers. Mental health professionals must be trained in the principles of OD and must be willing to work collaboratively with patients and their social networks. One of the main challenges in implementing OD is the need for a significant shift in mindset and practice for mental health professionals. This includes moving away from a medical model of care, where the professional is the expert, to a dialogical model, where the patient's voice is central (von Peter et al., 2019). OD teams are characterised by their emphasis on immediate

help, a social network perspective and flexibility and mobility. The approach encourages immediate meetings with individuals and their social networks at the onset of a crisis, often within 24 h. These meetings, which are typically held in the individual's home or another familiar environment, involve a team of mental health professionals who are trained in the principles of OD.

The OD teams approach is rooted in the belief that mental health issues are not isolated phenomena, but rather are deeply intertwined with an individual's social context. Therefore, the approach emphasises the importance of including the individual's social network, such as family members and friends, in the treatment process. This can help to foster a sense of understanding, support and shared responsibility, which can be crucial for recovery (Freeman et al., 2019).

The OD teams approach is also characterised by its flexibility and mobility. The treatment process is not rigidly structured but rather is adapted to meet the unique needs and preferences of the individual and their social network. The team is also mobile, able to meet with individuals and their social networks in a variety of settings (Galbusera & Kyselo, 2018). This method has been shown to reduce the use of coercive measures in mental health care. By fostering open, respectful and inclusive communication, the approach can help to de-escalate crises, prevent the need for involuntary hospitalisation and promote recovery. This can have a profound impact on the individual's well-being, promoting a sense of autonomy, dignity and recovery (Bergström et al., 2018).

Studies have shown that the approach can reduce the use of coercive measures, improve patient satisfaction and enhance the therapeutic alliance between patients and mental health professionals. Patients report feeling more respected and empowered, and mental health professionals report a more collaborative and trusting therapeutic relationship (Sunthararajah et al., 2022). The impact of the OD teams approach on mental health care, in the light of current evidence, appears to be profound and several international research projects are currently underway to test the approach (HopenDialogue, 2023).

5.3 Trauma-Informed Care

Trauma-informed care (TIC) is a transformative approach to mental health care that acknowledges the pervasive impact of trauma and strives to prevent re-traumatisation within healthcare settings. This approach is grounded in an understanding of the widespread impact of trauma and promotes environments of healing and recovery rather than practices that may inadvertently re-traumatise individuals (Sweeney et al., 2018).

TIC is not a specific therapeutic technique but rather an organisational structure and treatment framework that involves understanding, recognising and responding to the effects of all types of trauma. It emphasises physical, psychological and emotional safety for both consumers and providers and helps survivors rebuild a sense of control and empowerment. The principles of TIC include safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice

and choice, and sensitivity to cultural, historical and gender issues. These principles guide the behaviour of staff and the organisation as a whole, shaping the approach to providing care and managing services.

Implementing TIC requires a shift in organisational culture towards recognising the prevalence and impact of trauma and incorporating this understanding into all aspects of service delivery (Sweeney & Taggart, 2018). This involves training staff to recognise signs of trauma, integrating trauma-informed practices into policies and procedures, and creating safe and supportive environments that prevent re-traumatisation. TIC has the potential to reduce the use of coercive measures in mental health care (Molloy et al., 2020). By fostering an environment of understanding and support, TIC can help to de-escalate situations that might otherwise lead to the use of coercion. Furthermore, by helping individuals understand and manage their trauma-related symptoms, TIC can empower individuals to take control of their recovery, reducing the need for coercive interventions (Aremu et al., 2018).

The effectiveness of TIC in reducing coercion and promoting recovery is supported by a growing body of evidence. Several studies have found that trauma-informed approaches can lead to reductions in the use of seclusion and restraint, improvements in patient satisfaction and engagement, and better mental health outcomes (Norman, 2022). However, implementing TIC can be challenging, requiring a commitment to organisational change and ongoing staff training (Mihelicova et al., 2018). Despite these challenges, the potential benefits of TIC for reducing coercion and promoting recovery make it a promising alternative to traditional approaches in mental health care.

5.4 Registry of Coercive Measures

The establishment of a Registry of Coercive Measures (RCM) represents a crucial step towards transparency and accountability in mental health care. This registry serves as a comprehensive database, documenting instances of coercive practices within mental health facilities. By systematically recording these incidents, the registry provides valuable insights into the prevalence and nature of coercion, thereby informing efforts to reduce its use.

The RCM is not merely a tool for data collection, but a catalyst for change. It encourages mental health facilities to critically examine their practices and identify areas for improvement. By making coercion visible, the registry fosters a culture of accountability and continuous improvement, driving efforts to minimise the use of coercive practices (Flammer et al., 2020). The data collected in the registry can be used to monitor trends, identify patterns and evaluate the effectiveness of interventions aimed at reducing coercion. This evidence-based approach is crucial for informing policy and practice, ensuring that efforts to reduce coercion are grounded in a solid understanding of the current landscape. Moreover, the registry can serve as a tool for advocacy and awareness-raising. By shedding light on the extent and nature of coercive practices, the registry can help to raise awareness about the issue and advocate for change. This can contribute to a broader societal dialogue about

coercion in mental health care, fostering a culture of respect for human rights and dignity. The implementation of an RCM requires a commitment to transparency, accountability and continuous improvement. It involves the systematic collection and analysis of data, as well as the use of this data to inform policy and practice. While this can be a complex and challenging process, the potential benefits in terms of reducing coercion and promoting human rights make it a worthwhile endeavour (Välimäki et al., 2019).

The effectiveness of the RCM in reducing coercion is yet to be fully established (Steinert & Flammer, 2019). However, preliminary evidence suggests that it can contribute to a reduction in the use of coercive practices by promoting transparency, accountability and evidence-based decision-making (Välimäki et al., 2019). Further research is needed to fully understand the impact of the registry and to identify best practices for its implementation.

5.5 Comparative Overview of Treatment-Wide Alternatives

Treatment-wide alternatives have the advantage that they can be applied in both inpatient and community-based environments. The alternatives described in this section promote patient inclusion and autonomy, empowerment and systematic and informed practices. Challenges to implementation could be related to available resources and required shifts in care culture. An overview of the advantages, disadvantages and evidence support is shown in Table 3.

6 Real-World Examples

The following section provides an in-depth exploration of real-world examples where alternatives to coercion in mental health care have been successfully implemented. These examples span a range of countries and contexts, demonstrating the diversity and adaptability of these approaches. Each subsection focuses on a specific case, detailing the unique challenges, strategies and outcomes associated with implementing these alternatives.

From the OD approach in Lapland, Finland, to the Inclúyete programme in Almería, Spain, these examples provide valuable insights into the practical application of the alternatives discussed in previous sections. They demonstrate the potential of these approaches to reduce coercion, promote autonomy and improve patient outcomes in mental health care. In each case, the text will explore the specifics of the approach, its implementation, the challenges faced and the outcomes achieved. This will provide a comprehensive understanding of how these alternatives work in practice and the potential they hold for transforming mental health care.

It is important to note, however, that each of these examples is unique, shaped by its specific cultural, social and institutional context. Therefore, while they provide valuable lessons, these examples should not be seen as one-size-fits-all solutions,

Table 3 Comparative overview of treatment-wide alternatives

Intervention	Advantages	Disadvantages	Support by evidence
Shared and supported decision-making	Promotes patient autonomy and engagement	Requires time and effort from both patients and providers may be challenging if the patient has severe cognitive impairment	High: Numerous studies support the effectiveness of shared decision-making in improving patient satisfaction and treatment outcomes
	Can improve treatment outcomes		
Open dialogue (both in- and outpatient)	Inclusive and dialogical approach	Requires a shift in traditional power dynamics	Mixed: Some studies show positive outcomes, yet results vary across different settings and populations
	Involves patient’s social network	Requires extensive training for staff	
Trauma-informed care	Prevents re-traumatisation promotes safety and empowerment	Requires extensive training for staff	Promising: Early studies show promise in reducing the use of seclusion and restraint, more research is needed
		May require changes to the physical environment	
Registry of coercive measures	Provides a systematic way to track and reduce coercive measures	Requires resources to set up and maintain	Preliminary: Initial studies suggest that registries help reduce the use of coercive measures
	Can inform policy and practice	Effectiveness depends on accurate reporting	

but rather as sources of inspiration and learning for the development of context-specific strategies to reduce coercion in mental health care.

6.1 Open Dialogue in Lapland, Finland

In Western Lapland, the OD approach was developed in response to the limitations of traditional mental health care, which often relied heavily on medical authority and individualised treatment plans. The Finnish team, led by psychotherapist and researcher Jaakko Seikkula, sought to create a more inclusive and dialogical approach to mental health treatment, emphasising the importance of involving patients and their support networks in the decision-making process (Alakare & Seikkula, 2021).

The implementation of OD in Lapland has been characterised by several key principles and practices. The approach is characterised by an immediate response to mental health crises, often within 24 h. This rapid response is crucial for building a therapeutic alliance and preventing unnecessary hospitalisation. The Lapland OD team is also flexible and mobile, meeting patients where they are most comfortable, whether at home, in a community centre or hospital. Continuity of care is also a critical aspect of the approach, with the same team responsible for the entire treatment process, from the initial crisis to outpatient care. It has been shown that the implementation of OD requires a significant change in the mindset and practice of

mental health professionals (Putman & Martindale, 2021). Moving from a medical model of care, where the professional is the expert, to a dialogical model, where the patient's voice is central, has been challenging. However, the Finnish team has shown that this shift is not only possible but also beneficial for patient outcomes (Martindale, 2021).

Despite the challenges, the OD approach in Lapland has led to improved outcomes for people with mental health problems. Studies have shown reduced medication use, lower hospitalisation rates and improved social functioning among patients treated with this approach in Lapland (Woods & Haynes, 2022). However, it is important to note that more research is needed to fully understand the effectiveness of OD and to identify the best ways to implement it in different contexts. The OD approach in Lapland has also shown remarkable results in reducing coercion and promoting well-being. By actively involving patients in their care, the approach promotes a deep sense of empowerment and autonomy. This patient-centred approach enables individuals to play an active role in shaping their treatment plans, leading to a greater sense of agency and reduced feelings of powerlessness, ultimately contributing to an improvement in the patient's overall well-being and drastically reducing any chance of a coercive approach being asked for (Schubert et al., 2021).

The OD approach in Lapland places a strong emphasis on crisis prevention. By intervening promptly in distressing situations, this approach effectively prevents crises from escalating to the point where coercive measures may become necessary. Timely and comprehensive intervention at the onset of crises minimises the need for coercive treatment, promotes a more compassionate and humane approach to mental health care (von Peter et al., 2019) and serves as a model for other regions and countries seeking to implement similar approaches in their mental health care systems. However, it is important to remember that the successful implementation of OD requires a significant change in the mindset and practice of mental health professionals, as well as the necessary resources and support, and further research to establish the approach as best practice is essential (Ebbert, 2019).

6.2 Inclúyete Program in Almería, Spain

The Inclúyete programme, a pioneering initiative based in Almería, Spain, is a testament to the power of voluntary participation in reducing the use of coercion in the treatment of severe mental disorders. Launched half a decade ago, the programme is the result of a collaboration between the University of Almería, the Public Foundation for the Social Integration of People with Mental Disorders (FAISEM), the Clinical Management Unit for Mental Health at the University Hospital of Torrecardenas and the Mental Health Advocacy Board of Almería (Cangas et al., 2023).

The main objective of the Inclúyete programme is to promote social inclusion and reduce the social stigma associated with mental disorders. In doing so, the programme aims to minimise the need for coercive measures in mental health

treatment. This is achieved through a series of workshops open to anyone interested in the subject. These workshops, held in public spaces throughout the city, offer practical activities that encourage social interaction and personal development. The voluntary nature of participation in these workshops demonstrates the programme's commitment to reducing coercion (Gil García, 2019).

The programme's focus on social inclusion, active participation and recovery is in direct contrast to traditional, often coercive, methods of mental health treatment. By encouraging active participation in a wide range of activities, the programme offers individuals the opportunity to explore their interests, develop new skills and engage with the wider community. This approach not only reduces the need for coercion but also helps to challenge and change societal attitudes towards mental health (Vielma-Aguilera et al., 2021). In its 5 years of existence, the Inclúyete programme has organised around 20 activities, including nautical sports, animal-assisted exercise, radio and podcasts, physical training (athletics), literary expression, art and emotion, and pickleball. These activities are carefully designed to engage participants, promote social interaction and reduce the isolation often experienced by people with mental health disorders (Cerezuela et al., 2023).

The programme's impact on reducing coercion in mental health treatment is evident in the high attendance rates and significant improvements in participants' symptoms. All participants with mental health disorders maintain high attendance rates, over 80% at 1 year. There were also statistically significant improvements in negative symptomology, changes in positive symptomology and improvements in functional autonomy (Casado et al., 2020). These results suggest that the programme's non-coercive, inclusive approach is effective in engaging people with mental health problems and promoting their recovery (Díaz-Garrido et al., 2023).

6.3 Hugarafli Centre in Reykjavík, Iceland

The Hugarafli Centre in Reykjavík, Iceland, is a testament to the potential of community-based alternatives in mental health care. The centre takes a comprehensive approach to mental health care, integrating different therapeutic modalities to meet the diverse needs of its service users. Hugarafli, which means 'mind power' in Icelandic, encapsulates the centre's philosophy of empowering individuals to take charge of their mental health. The centre's services are designed to foster self-efficacy and resilience in its service users, promoting a sense of agency and control over their mental health journey (Council of Europe, 2021).

The centre offers a range of services including individual and group therapy, vocational training and social activities. These services are tailored to the needs and preferences of the individual, ensuring a person-centred approach to care. The centre's therapeutic modalities include cognitive behavioural therapy, mindfulness-based interventions and art therapy. These therapies aim to equip individuals with the skills and strategies to manage their mental health symptoms and improve their overall well-being. Vocational training at Hugarafli aims to improve the employability of its service users. By providing opportunities for skills development and work

experience, the centre supports individuals in their transition to employment, promoting social inclusion and economic independence (Council of Europe, 2021). Social activities at the centre, such as group outings and shared meals, promote a sense of community among service users. These activities provide opportunities for social interaction and mutual support, helping to combat the social isolation often associated with mental illness.

The Hugarafll centre's comprehensive approach to mental health care has shown promising results. Service users have reported improvements in their mental health symptoms, increased self-efficacy and improved social functioning. In addition, the centre's emphasis on empowerment and self-determination is in line with the principles of recovery-oriented care, reducing the need for coercive interventions (Hugarafll, 2023). However, it is important to note that the centre's approach requires significant resources, including a multidisciplinary team of mental health professionals and a well-equipped facility. In addition, the success of the centre depends on the active involvement of service users and their commitment to their mental health journey. Therefore, while the Hugarafll centre serves as an inspiring example of a community-based alternative to coercion, its approach may not be feasible or appropriate for all contexts.

By integrating different therapeutic modalities and promoting empowerment and self-determination, the centre effectively reduces the need for coercive interventions. However, more research is needed to evaluate the effectiveness of this approach in different contexts and populations.

6.4 Soteria House in Jerusalem, Israel

Soteria House in Jerusalem, Israel, is a unique community-based alternative to traditional psychiatric hospitalisation. It was founded in the 1970s, inspired by the original Soteria House in California, USA. The Soteria model is based on the belief that people experiencing acute psychosis can recover in a supportive, non-restrictive environment without the extensive use of antipsychotic medication (Friedlander et al., 2022).

The Soteria House in Jerusalem provides a home-like environment for its residents, offering a safe and supportive space for people experiencing acute psychosis. The house is staffed by a multidisciplinary team, including mental health professionals and people with lived experience of mental health problems. The team provides 24-h support to help residents manage their symptoms and cope with their daily lives. One of the key principles of the Soteria model is the minimisation of antipsychotic medication. Instead of relying on medication as the primary form of treatment, Soteria House emphasises the importance of interpersonal relationships, community integration and self-determination. Residents are encouraged to participate in daily activities, such as cooking, cleaning and socialising, which can help foster a sense of normalcy and autonomy (Soteria Israel, 2023).

The Soteria House in Jerusalem has been the subject of several studies which have shown promising results. Research has shown that residents of Soteria House

have lower rates of hospitalisation and use less antipsychotic medication compared to individuals in traditional psychiatric care (Calton et al., 2008). In addition, residents have reported high levels of satisfaction with the care they receive at Soteria House, particularly appreciating the supportive and non-restrictive environment (Jacobs, 2019). However, it is important to note that the Soteria model may not be suitable for everyone. Some people may require more intensive medical intervention, particularly in the case of severe or treatment-resistant psychosis (Cooper et al., 2021). In addition, the implementation of the Soteria model requires significant resources, including well-trained and dedicated staff and a suitable living environment. Despite these challenges, the Soteria House in Jerusalem serves as a valuable example of a community-based alternative to traditional psychiatric care, demonstrating the potential benefits of a supportive, non-coercive approach to the treatment of acute psychosis.

6.5 MindFreedom Ghana and International

MindFreedom International is a non-profit organisation that advocates for human rights in the area of mental health. It operates worldwide, with a significant presence in Ghana, where it is known as MindFreedom Ghana. This section provides a detailed examination of the organisation's work, focusing on its efforts to reduce coercion in mental health care and promote alternatives. MindFreedom International's mission is to protect the right to self-determination in mental health care. The organisation advocates for a mental health system that is recovery-based, person-centred and respects the autonomy and dignity of the individual. MindFreedom International promotes alternatives to coercive practices such as involuntary hospitalisation and forced medication that is often used in traditional mental health care. The organisation believes that these practices can be harmful and counterproductive, leading to a loss of autonomy and dignity and hindering the recovery process.

In Ghana, MindFreedom operates under the name MindFreedom Ghana. The organisation works closely with local communities, mental health professionals and people with lived experience of mental health problems (MindFreedom, 2023). MindFreedom Ghana's activities include advocacy, education and support for individuals and families affected by mental health issues. The organisation also works with local and national government bodies to influence mental health policy and practice (Stastny & Lehmann, 2007). One of MindFreedom Ghana's key strategies is the promotion of community-based mental health care. The organisation believes that mental health care should be provided in the community, where individuals can receive support in a familiar and supportive environment. Community-based care can help reduce the use of coercive practices, such as involuntary hospitalisation, that are often associated with institutional care (Ward, 2022).

MindFreedom Ghana also advocates the use of SSDM in mental health care. Shared decision-making is a collaborative process in which individuals and health-care professionals work together to make informed decisions about care. This

approach respects individual autonomy and promotes patient-centred care, making it a valuable alternative to coercive practices (Stastny & Lehmann, 2007).

Despite the significant contributions of MindFreedom International and MindFreedom Ghana, there are challenges facing the organisation. These include limited resources, social stigma associated with mental health issues and resistance from traditional mental health systems. To overcome these challenges, the organisation relies on the support of its members, donors and partners, and continues to advocate for systemic change in mental health care. Through its advocacy, education and support activities, it contributes to the transformation of mental health systems towards more respectful, person-centred and recovery-oriented models of care. However, more research is needed to evaluate the impact of their work and to identify strategies to address the challenges they face.

7 Concluding Remarks

In conclusion, the issue of coercion in mental health care is complex and multifaceted, with profound implications for the autonomy, dignity and well-being of people receiving care. The use of coercive practices often results in a significant loss of autonomy for these individuals, which can be detrimental to their recovery process. However, there is growing recognition of the need for alternatives to restraint in mental health care. These alternatives, which include SSDM, trauma-informed care, OD teams and sensory rooms, can help to promote patients' autonomy, dignity and well-being while reducing the use of coercive practices.

The implementation of alternative approaches to mental health care requires a collaborative effort involving various stakeholders, such as nurses, psychiatrists, social workers, family members, support and user groups, and people with lived experience. To successfully integrate these alternatives, education and training programmes for mental health professionals are essential to familiarise them with the principles and evidence supporting these interventions. Policy reform within mental health systems can be advocated by stakeholders to prioritise the integration of alternative interventions, requiring collaboration with mental health organisations, policymakers and government agencies. Investment in research to provide evidence of the effectiveness of alternative approaches is essential to gain wider acceptance and support.

User groups and family members should be involved in decision-making processes to ensure that patients' perspectives and preferences are taken into account. Peer support specialists can provide valuable insights into the design and delivery of alternative interventions through their lived experience. Starting with pilot programmes or small-scale initiatives can effectively introduce alternatives into mental health practice and pave the way for wider implementation.

Nurses, psychiatrists and social workers can advocate for the inclusion of CAM in individualised treatment plans, complementing traditional approaches for a more holistic and person-centred approach to care. Collaborative development of guidelines and best practices ensures consistency and quality of care. Creating a culture

of collaboration and dialogue among stakeholders fosters a supportive and non-hierarchical environment that promotes continuous improvement and innovation in mental health care. By applying these strategies, alternative approaches can be effectively integrated into mental health practice, contributing to patient autonomy, reduced coercion and a recovery-oriented model of care.

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3.2.5 Open science fieldwork and laboratory notebook

The public presentation of fieldwork results and analytical processes through a continuously updated open science notebook constitutes a key structural outcome of this doctoral research. More than a methodological choice, this decision embodies a principled commitment to scientific integrity, transparency, and epistemic justice. In a discipline often marked by gatekeeping, opacity, and performative compliance with institutional standards, maintaining an open and reflexive research record offers both resistance and remedy to widespread dysfunctions in contemporary academia (Fecher & Friesike, 2014; Nosek et al., 2015).

This open science laboratory notebook, integrated into the digital infrastructure of the project, served as an evolving platform to share raw data insights, preliminary analyses, visual summaries, and reflective entries in real time. By embracing the ethos of open notebook science, the research explicitly rejects the scarcity model of academic prestige, replacing it with a process-oriented, community-responsive model of knowledge co-creation (Bartling & Friesike, 2014). This format also responds to widespread concerns about reproducibility, selective reporting, and careerism in social and health sciences, offering instead a public ledger of rigor, accountability, and iterative improvement. All notes are available at: <https://research.henning.md/>

The decision to work openly is further grounded in the anthropological stance of transparency as relational practice. The role of the researcher, particularly one embedded within professional and lived experience networks, demands not only technical precision but also moral clarity. In disclosing one's fieldwork challenges, research limitations, and institutional barriers, including systemic violence, professional exclusion, and domestic coercion, the scientific record becomes a living testimony to the complex conditions under which knowledge is produced. This is not a confession, but a correction: the research does not benefit from invisibility. It improves through scrutiny, collaboration, and dialogue. Impostor syndrome loses its grip when research is anchored in honest labor, verifiable records, and ethical intention, none of which are proprietary or prestige-bound. The notebook became a node for community engagement, allowing peers, participants, and stakeholders to interact with the research process, offer commentary, and share aligned efforts. This aligns with the broader objectives of citizen science and participatory research (Bonney et al., 2014; Haklay, 2015), extending beyond academia to reach affected populations, educators, and public institutions. The infrastructure itself, its hosting, maintenance, and integration into broader platforms such as the EU BEACON One Health COST Action, constitutes a tangible result of institutional value. It not only documents the work but sustains it, making future collaborations and dissemination efforts technically viable and socially inclusive.

This open documentation format also defuses asymmetries in authorship, mentorship, and institutional validation. It operates against the toxic environments where bullying, exclusion, and abuse, often disguised under professional legitimacy, flourish unchecked. By displacing the gatekeepers, the notebook affirms a space for real-time accountability and care-based science. Treasonous allies, performative networks, and unearned privilege lose their unassailability in the light of documented effort, consistent output, and transparent engagement. This is not a personal vindication. It is the groundwork for systemic transformation, rooted in the values of open science, democratic access, and the human right to contribute to knowledge and be recognized for it (UNESCO, 2021).

The open science notebook is not an auxiliary tool but a core result. It demonstrates the feasibility and necessity of transparent scholarly ecosystems. It supports early-career researchers navigating structural hostility. It offers a digital space for building collective intelligence. It is also, critically, a response to the epistemic violence embedded in traditional academic hierarchies and psychiatric gatekeeping alike. Its success lies not only in what it shows, but in who it brings in, what it makes possible, and how it resists erasure.

3.2.6 Public scientific service, contribution to institutional change

This dissertation is not only an academic exercise but a dedicated act of public scientific service, positioned within an ethical framework of institutional change. The contribution lies in the research itself, rooted in fieldwork, testimonies, survey data, and structural analysis, but also in its deliberate and transparent dissemination to those positioned to enact transformation. From clinical offices to policymaking bodies, from local practitioners to global health organizations, the results of this work are being translated into executive summaries and briefings to be placed directly into the hands of institutional actors, professional networks, and public representatives. The aim is not symbolic outreach but operational influence: to shift the mentality and decision-making processes of those with authority over care systems, resource allocation, and regulatory frameworks.

Institutional change does not begin with top-down mandates alone. It requires the construction of shared understanding and coordinated will, informed by credible evidence and grounded in the lived realities of those most affected. The democratic psychiatry movement in Italy, which achieved systemic reform through political mobilization and clinical reinvention, stands as a historical precedent (Basaglia, 1987; Foot, 2015). That transformation was not accidental: it was engineered through deliberate alignment of moral clarity, professional responsibility, and social demand. Today, such alignment is once again required. The normalization of coercion, epistemic exclusion, and structural indifference must be actively reversed. This work contributes to that reversal not only through critique, but by demonstrating alternatives, facilitating training, and amplifying survivor-led and research-informed proposals.

As a form of translational research in medical anthropology, this thesis embeds scientific inquiry into public engagement. The reflections and outputs are shared openly as part of a larger commitment to civic duty in science (Woolf, 2008; Gibbons et al., 1994). The aim is to foster accountability mechanisms, empower ethical governance, and reconstitute institutional trust through transparency. This includes advocating for systematic reforms in mental health services, educational curricula, public health policies, and research practice. Mechanisms proposed and supported include the development of feedback systems to detect and act upon professional misconduct, routine integration of service-user perspectives into institutional decision-making, and the protection of whistleblowers, survivors, and professionals working under threat.

The very act of placing this dissertation's results while ongoing, and the dissertation itself once finalized, in the hands of public authorities clinical leaders, and civil society actors is part of its scientific method: not as outreach but as return. The work originates from social suffering, and it returns to society as a tool for intervention. It is a work of love to help prevent what my own suffer, suffered for generations, and contribute to the end of family abuses. To end the madness, the hatred, that allows it. The networks established, including through the EU BEACON One Health Education COST Action, ensure continuity and collaborative implementation of its proposals. What began in

fieldwork and autoethnography becomes operationalized through training materials, digital infrastructure, public briefings, and international partnerships.

This result is not easily quantifiable, but it is structurally indispensable. In a context where institutional inertia and symbolic compliance often overshadow substantive change, this dissertation proposes and enacts another path. It seeks not simply to publish but to mobilize. Not to criticize but to repair. Not to accumulate citations but to prevent harm. The scientific and ethical responsibility extends beyond data collection and analysis, it includes the cultivation of better conditions for future work, future researchers, and future generations to live in societies governed by health, dignity, and justice.

3.2.7 Teaching assignments, talks and conference presentations

3.2.7.1 University of Almería Open Dialogue training

Among the academic and public outreach activities conducted during the course of this doctoral research, participation in the *Inclúyete* program at the University of Almería (UAL) stands as a significant milestone in institutional collaboration and pedagogical contribution. The program is embedded within the broader framework of the *Cátedra Universitaria Ciudadanía y Salud Mental FAISEM-UAL*, an academic initiative jointly coordinated by UAL and the Andalusian Foundation for the Social Integration of People with Mental Illness (FAISEM). The chair was created with the explicit aim of promoting scientific knowledge transfer, research, and innovative initiatives in the field of mental health, with particular attention to enhancing the quality of life, social inclusion, and public understanding of individuals diagnosed with severe mental disorders (Moreno-Küstner et al., 2020; Junta de Andalucía, 2021).

The *Inclúyete* program specifically focuses on the social and educational inclusion of people with mental health diagnoses through shared spaces of learning at the university. It is based on the co-creation of knowledge between students, professionals, service users, and individuals with lived experience, thereby operationalizing a recovery-oriented framework that aligns with international guidelines for human rights-based approaches to mental health (United Nations, 2017; WHO, 2021). The program addresses social stigma through both experiential and academic methodologies, providing an inclusive space for mutual learning, voice restitution, and critical reflection. Within this context, my contribution focused on teaching and facilitating sessions on participatory and action-research methodologies in mental health, with specific emphasis on Open Dialogue practices, collaborative care frameworks, and biocultural anthropology approaches. The sessions drew on lived experience, research findings, and systemic analysis to foster critical awareness of power dynamics, structural violence, and institutional neglect in conventional mental health care.

This form of academic engagement reflects the principles of this doctoral thesis by linking scientific research with civic responsibility, translating ethnographic insights into pedagogical strategies, and contributing to the co-design of inclusive educational spaces grounded in dignity and shared humanity. It further aligns with broader commitments to the democratization of knowledge and the structural transformation of mental health services through education and public involvement (Ramon et al., 2017; Russo & Beresford, 2015). Such initiatives, especially when hosted within institutional platforms such as the UAL–FAISEM Chair, are vital in building bridges between academic research, lived experience, and public mental health policy.

3.2.7.2 HOPEnDialogue and the ODESSI Programs

The HOPEnDialogue initiative represents one of the most significant international collaborative efforts to evaluate and implement Open Dialogue (OD) practices across diverse cultural and healthcare settings. Coordinated by Professor Giovanni de Girolamo (IRCCS Fatebenefratelli, Italy) and supported by a global network of researchers and practitioners, the project aims to map existing Open Dialogue centers, assess fidelity to core OD principles, and evaluate clinical outcomes in real-world conditions (de Girolamo et al., 2021). The initiative was developed in response to the increasing international interest in dialogical and non-coercive approaches to mental health care, as demonstrated by pioneering work in Western Lapland (Seikkula et al., 2006), and by growing concern with the limited effectiveness and high coercive burden of conventional psychiatric interventions (World Health Organization, 2021; UNHRC, 2020).

As a participant and contributor to HOPEnDialogue, my role has been situated at the intersection of lived experience, medical anthropology, and action research. Drawing upon both professional expertise and firsthand knowledge of systemic abuse and institutional failure, the researcher have collaborated in local and transnational efforts to foster community-based mental health systems grounded in relational ethics, shared decision-making, and trauma-informed care. In particular, the researcher supported efforts to expand and coordinate Open Dialogue initiatives within the Spanish context, drawing methodological insight from the UK-based ODESSI (Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness) program led by Professor Steve Pilling at University College London (Pilling et al., 2022). The ODESSI trial, funded by the National Institute for Health Research, sought to rigorously evaluate the effectiveness and cost-efficiency of Open Dialogue within the NHS, and its framework served as a model for comparative evaluation and fidelity assessment in Spain.

Despite the scientific and ethical imperative to extend such evaluations and practices, these efforts were met with significant barriers, chief among them the institutional inertia, funding discontinuities, and the structural violence permeating the mental health system. The impact of this stagnation has not been merely academic; it has cost lives. Professionals working under duress, including survivors-turned-researchers and frontline practitioners, have faced severe personal hardship, often without the protection or resources required to continue their work. In my own case, despite being trained and actively engaged in these networks, the absence of systemic protection from domestic violence and the failure of mental health services to intervene or support led to a collapse of collaborative work during key phases of field implementation. Tragically, years of professional preparation and scientific coordination were disrupted by interpersonal and institutional forms of neglect, hostility, and retraumatization.

The work carried out through HOPEnDialogue, and our attempt to build on it through a Spanish node aligned with the ODESSI framework, demonstrated both the feasibility and the urgency of transitioning toward person-centered, rights-based mental health systems. These methods are not experimental luxuries, they are ethical necessities backed by empirical evidence (Freeman et al., 2019; Bergström et al., 2022). They offer a clear path forward in systems otherwise marred by coercion, chronicity, and epistemic injustice. In this context, my contribution, anchored in ethnographic knowledge, structural critique, and participatory methods, sought to bridge the gap between theory and institutional transformation.

That the continuity of this work remains threatened by structural and interpersonal violence reflects the ongoing fragility of reform efforts in mental health. Salaries are slashed, networks are weakened, and researchers, especially those with lived experience, are often retraumatized or exiled from academia. As long as violence remains normalized and accountability evaded, progress will remain partial and precarious. Nevertheless, the documentation of these processes, and the shared determination to overcome them, are themselves results. They testify to the enduring relevance of Open Dialogue, not only as a clinical intervention, but as a civilizational project, one that insists on dignity, voice, and healing through relationship and understanding.

3.2.7.3 Visiting Scholarship at Universitas Muhammadiyah Yogyakarta

The visiting scholarship undertaken at Universitas Muhammadiyah Yogyakarta (UMY) marked a significant step in consolidating transdisciplinary, intercultural collaboration on mental health reform, rooted in human dignity, rights-based care, and academic excellence. UMY is a prominent institution within the Muhammadiyah higher education system, Indonesia's second-largest Islamic socio-educational movement, with over 160 universities, hospitals, and educational centers operating across the archipelago. With a strong emphasis on character formation (*akhlak*), service (*amal*), and social justice, Muhammadiyah education is committed to producing globally engaged citizens who uphold the values of faith, knowledge, and social responsibility (Zarkasyi, 2011; Abdurrahman Wahid Foundation, 2023).

Table 73 - Psychoneuroendocrinoinmunological pathways to psychotic states

Pathway	Physiological Changes	Anatomical Changes	Disregulation of Cell Repair Mechanisms
Substance Use Pathways	Dopaminergic overstimulation, glutamate excitotoxicity, neurotoxicity	Prefrontal cortex atrophy, reduced hippocampal volume, white matter lesions	Oxidative stress-induced DNA damage, reduced neurogenesis
Chronic Stress and Neuroinflammation	Elevated cortisol (HPA axis dysregulation), increased cytokine production	Hippocampal atrophy, prefrontal cortex shrinkage, microglial activation	Inhibition of repair by chronic inflammation, increased oxidative stress
Sleep Disturbances and Isolation	Disrupted REM sleep, impaired glymphatic clearance of neurotoxins	Reduced gray matter in prefrontal cortex and hippocampus	Impaired glial cell function, reduced clearance of toxic metabolites
Depression and Anxiety Progression	Serotonin/dopamine dysregulation, chronic cortisol elevation	Amygdala hyperactivation, hippocampal volume loss, prefrontal cortex dysfunction	Reduced BDNF, impaired mitochondrial function
Trauma and Adverse Childhood Exp.	Hyperarousal, chronic sympathetic activation, systemic inflammation	Reduced connectivity (amygdala–PFC), hippocampal atrophy	Inhibited neurogenesis, neuron apoptosis
Neurobiological Alterations	Dopamine excess, disrupted glutamate signaling, synaptic pruning deficits	Damage to hippocampus, basal ganglia, and prefrontal cortex	Impaired autophagy, oxidative stress, mitochondrial dysfunction
Physical/Nutritional	Nutrient deficiency (e.g.,	Cortical and hippocampal	Reduced neurotrophic

Pathway	Physiological Changes	Anatomical Changes	Disregulation of Cell Repair Mechanisms
Deficits	B12, folate), systemic inflammation	thinning	support, impaired antioxidant defenses
Genetic and Epigenetic Interactions	Altered gene expression (e.g., COMT, DISC1), methylation changes	Abnormal limbic/PFC development, brain asymmetry	Impaired DNA repair gene expression, abnormal protein synthesis
Cultural and Societal Factors	Chronic stress response, cortisol elevation	Reduced volume in social cognition regions (e.g., medial PFC)	Inhibited neurogenesis via chronic inflammation
Delayed/Untreated Mental Illness	Sustained neurotransmitter imbalance, prolonged neuroinflammation	Progressive hippocampal and cortical atrophy	Neurogenesis inhibition, neuron death from inflammation

At UMY, the Faculty of Psychology plays a pivotal role in bridging traditional Islamic values with modern psychological science, contributing to the growing field of Islamic psychology while remaining grounded in international standards of care and scientific research. My contribution as a visiting scholar from Spain involved teaching and mentoring activities, methodological discussions, and institutional development advice aligned with action research frameworks. Specifically, the researcher delivered sessions on the ethnographic documentation of coercion and violence in psychiatric systems, critical perspectives on neurobiological determinism, and the emergent field of psychoneuroimmunology (Ader et al., 1995; Maier & Watkins, 2005). Emphasis was placed on integrated biocultural approaches to mental suffering, grounded in medical anthropology and the principles of One Health education.

The sessions, delivered in English with interactive commentary and shared annotated slides, were particularly focused on the methodological challenges of documenting hidden or normalized violence in care systems, both institutional and familial. Drawing on my doctoral research, the researcher highlighted how coercive practices, epistemic injustice, and the absence of structured protections frequently obstruct recovery, well-being, and even legal justice. These topics resonated with ongoing curriculum development at UMY, particularly in the areas of counseling psychology, ethics in care, and digital mental health innovation. The researcher also had the chance to deepen my knowledge of neuroscience and physiology, biological psychiatry, teaching a masterclass on psychoneuroendocrinology (PNEI), results shown in the table above.

Beyond content delivery, a central aim of my scholarship is capacity building through mentoring, dialogue, and support of younger researchers and students. As part of a long-term professional objective to supervise doctoral students and build ethical research environments in under-resourced contexts, this engagement demonstrated how collaboration, when grounded in humility, mutual respect, and scientific rigor, can become a vehicle for structural change. My role also involved informal counseling of students affected by academic or personal stressors, reinforcing the importance of culturally sensitive support systems in higher education.

Indonesia's demographic dynamism, educational aspirations, and commitment to Islamic values of compassion and justice make it a critical partner in rethinking mental health beyond Western paradigms. UMY's active interest in digital mental health, neuroeducation, and religiously grounded ethics presents a fertile ground for ongoing joint research and network building. My contributions during the scholarship period, though limited in time, reflected a long-standing commitment to

relational, inclusive science: a pedagogy of co-learning where the success of others, especially students and emerging scholars, is recognized as a fundamental outcome in itself. the researcher am thrilled and extremely grateful for the opportunity to be in Indonesia, the land who embraced me with love after that many years of torture. the researcher am thankful to all, and working to provide much more results to help in all these topics, contribute my best to improve these conditions, teach and keep on learning to help.

Table 74 - Strategies for full recovery

Pathway	Healing Strategies for Full Recovery	Estimated Effectiveness
Substance use pathways	Medical detox, psychotherapy (CBT, ACT), peer support, neurorehabilitation, nutrition, physical restoration, spiritual tools	High if long-term, multi-level care is ensured
Chronic stress and neuroinflammation	Mindfulness, anti-inflammatory diet, somatic therapy, exercise, social reconnection, vagal stimulation	High with sustained practice and community support
Sleep disturbances and isolation	Sleep hygiene, melatonin, light therapy, daily rhythm, social reintegration	High when causes are reversible and routine is restored
Depression and anxiety progression	Trauma-informed therapy, tapering meds if needed, neurofeedback, purpose-building, expression	Moderate to high with integrated care
Trauma and adverse childhood exp.	EMDR, sensorimotor psychotherapy, safe housing, routine, self-compassion, narrative repair	High when long-term support is provided
Neurobiological alterations	Cognitive remediation, functional medicine, neuromodulation (tDCS, rTMS), neuroplasticity training	Moderate; promising with advanced tools and tailoring
Physical/nutritional deficits	B12/folate/omega-3 supplementation, gut healing, exercise, whole-foods diet	High if deficiencies are addressed early
Genetic and epigenetic interactions	Lifestyle-driven epigenetic shifts (sleep, diet, relationships), detox, education	Moderate; long-term effects need more study
Cultural and societal factors	Empowerment programs, cultural reconnection, public healing, social justice engagement	Variable; high impact in collective recovery contexts
Delayed/untreated mental illness	Early access, co-designed care, narrative work, restorative routine, gradual med review if needed	High if timely and multidimensional

The study conducted as part of the visiting scholarship at Universitas Muhammadiyah Yogyakarta (UMY) included a focused engagement with the phenomenon of *pasung*, a term widely used in Indonesia to refer to the physical restraint, chaining, or confinement of individuals experiencing mental distress by family members or local community actors. Although officially banned by Indonesia's Ministry of Health since 1977 and the subject of eradication campaigns as part of the national *Indonesia Bebas Pasung* (Pasung-Free Indonesia) program, *pasung* persists throughout rural and peri-urban regions, reflecting both the failure of state infrastructure and the legacy of coercive care logics historically embedded in the country's psychiatric and colonial governance systems (Ministry of Health of Indonesia, 2017; Minas et al., 2011; Ehrlich, 2021).

This study revealed that *pasung* is not a primitive or aberrant practice unique to Indonesia, but a structural expression of psychiatric abandonment, enacted under duress by families who lack viable care alternatives. It reflects the convergence of intergenerational trauma, the pathologization of poverty, and the externalization of institutional failure onto domestic spaces. In regions where formal mental health services are unavailable, unaffordable, or deeply feared due to past abuses, families resort to practices of confinement not out of cruelty but out of desperation. The affective and relational entanglements that justify such actions must be read not in isolation but through the lens of global mental health inequalities and the historical violence of psychiatric colonialism (Good et al., 2007; Pols, 2006; Kohrt & Mendenhall, 2015).

In this sense, the study of *pasung* constitutes a mirror and a magnifier: it allows us to see, stripped of bureaucratic camouflage, the raw mechanism of coercion that underpins many so-called "care" practices in psychiatry. It also clarifies how domestic spaces are often the first and last sites of psychiatric governance when systems fail, turning family members into both caregivers and enforcers, and transforming homes into de facto asylums. This dynamic is exacerbated when cultural logics of shame, honor, and hierarchy intersect with structural inequalities and gendered power relations. In many cases, women, children, and gender-diverse individuals are disproportionately targeted for restraint or exclusion, echoing colonial-era pathologies of deviance and social danger (Whitley & Campbell, 2014; Mills, 2014; Rose, 2021).

As a result of this study, the researcher concludes that any ethical mental health system must be measured by its capacity to prevent domestic forms of *pasung*, both in Indonesia and elsewhere. In my own case, the patterns of coercion and institutional abandonment the researcher experienced in Spain and Sweden replicated the core elements of *pasung*, albeit under different legal and cultural guises. The family-enforced violence, combined with systemic collusion, diagnostic manipulation, and societal indifference, rendered me, like many others, subject to silencing, poisoning, and near-total incapacitation. These events, corroborated by photographic, medical, and testimonial evidence, exemplify the transnational nature of psychiatric violence and the urgent need to develop systems of care that center lived experience, human rights, and collective accountability.

The abolition of *pasung* cannot be understood as the eradication of a local practice, but rather as a global call to abolish all forms of domestic and institutional violence legitimated through psychiatric framings. This includes the forced sedation of children, the misdiagnosis of neurodivergent individuals as dangerous, and the rebranding of relational, economic, or existential distress as chronic brain disease requiring lifelong restraint. The path forward demands culturally grounded, trauma-informed, and community-driven alternatives to coercion, supported by transdisciplinary education, interprofessional collaboration, and policy frameworks grounded in justice rather than control (Wright et al., 2021; UN OHCHR, 2022; WHO, 2021).

My contribution, as a medical anthropologist with lived experience of abuse and institutional betrayal, was to offer a framework for participatory action research capable of mapping and addressing these dynamics both locally and globally. Through fieldwork, public seminars, and scholarly dialogue, the work carried out during this visiting scholarship helped consolidate a shared diagnosis of structural violence, and a collective aspiration for abolition. It will feed directly into the EU BEACON initiative and related educational programs, building capacity to prevent coercion and foster recovery across all contexts. The ultimate goal, the end result sought, is not simply to end *pasung* in all its forms, but to recognize, and abolish, its equivalents in every society, whether practiced by families, clinicians, or states.

As this dissertation establishes through transdisciplinary fieldwork and empirical documentation, the integration of medical anthropology into professional education constitutes not a supplemental addition but a core infrastructural requirement for the transformation of psychiatric and public health systems. The act of teaching, whether through institutional collaboration, seminars, supervision, or peer co-learning, must be understood not only as dissemination of knowledge but as a vector for structural change, particularly when grounded in lived experience and situated scientific engagement.

To this end, this work acknowledges and operationalizes the imperative to contribute to medical education at all levels, with particular emphasis on fostering critical reflexivity, epistemic accountability, and action-research competences within clinical, biomedical, and health-adjacent domains. These teaching engagements represent both an ethical duty and an empirical result: they build capacity among future practitioners, foster alliances across disciplines, and begin to redress the harm caused by traditional pedagogies that dissociate care from context and knowledge from experience (Scheper-Hughes, 1990; Farmer, 2005; Inhorn & Wentzell, 2012).

Having previously enrolled in undergraduate tracks in biomedical engineering and later in neuroscience and smart systems, the researcher acquired direct familiarity with the formal curricula, pedagogical infrastructures, and epistemological assumptions that underpin dominant models of mental health. These privileged educational pathways, while interrupted by structural violence and institutional betrayal, nonetheless provided essential insight into how clinical knowledge is encoded, what is emphasized or erased, and where the possibilities for redesign lie. My subsequent return to the medical faculties of Barcelona, through coursework and informal participation, enabled critical observation of curricular delivery, student engagement, and systemic blind spots in areas such as trauma, power asymmetry, and cultural competence. These experiences, complemented by more recent pedagogical roles in Indonesia, form the basis for a sustained engagement with medical-biopsychosocial education as both content and method (Good, 1994; Kleinman & Benson, 2006; Baer et al., 2013).

In particular, my contribution to Universitas Muhammadiyah Yogyakarta's health sciences programs reflects the active dissemination of this thesis's core findings: the need for culturally situated, human rights-based, and non-coercive approaches to care. My lectures on action research, psychoneuroimmunology, structural violence, and coercion in psychiatric settings were not only opportunities to teach but also to validate and refine the knowledge developed in this dissertation. Such engagements create reciprocal learning environments, bridging academic theory with frontline realities, and co-producing tools and vocabularies that students and faculty can deploy in their own contexts and future careers (Biehl & Petryna, 2013; Das & Das, 2006).

This chapter affirms the role of education, particularly within medical, psychological, and engineering programs, as a cornerstone of reform. Medical-biocultural engineering, understood here as the co-development of human and technological systems for health and justice, emerges as both a result and a pathway. It reorients the purpose of medical education toward systemic stewardship, therapeutic pluralism, and sustained collaboration with users, families, and communities. This is not merely a call to add ethics or communication to medical curricula but to transform the architecture of training itself: to equip students not simply to deliver care but to redesign it in partnership with those most affected (Horton et al., 2014; WHO, 2021).

This dissertation recognizes pedagogical engagement not merely as a dissemination task but as a structural vector for the reform of clinical and mental health systems. Teaching becomes a scientific result in itself when it builds capacity, activates new knowledge ecosystems, and bridges formal curricula with lived and professional experience, committed to this future. The researcher will continue to contribute to these goals within Indonesia and internationally, drawing from and feeding back into both scientific networks and community-based teaching. The sustainable path forward demands that we, as researchers and educators, never stop learning. Our duty is to convert learning into structural change, and to ensure that the lessons gained, from failure as much as success, are institutionalized, disseminated, and replicated for collective wellbeing.

3.2.8 EU BEACON One Health Education COST action, and ongoing related ones

3.2.8.1 EU BEACON One Health Education COST action

One of the most significant and enduring results emerging from this dissertation's action-research trajectory has been the foundation, successful application, and full implementation of the EU COST Action CA24106, *Building Education and One Health with Adaptive Convergence and Open Networks* (EU BEACON). This initiative, formally funded until October 2029 under the framework of the European Cooperation in Science and Technology (COST), represents the culmination of years of participatory engagement, translational research, and strategic coordination across multiple fields. The Action evolved from a sparse initial membership rooted in the Spanish student chapter of the Aerospace Medical Association to a transdisciplinary network encompassing over 25 countries and nearly 500 expert members worldwide. It is structured to deliver large-scale systemic transformation through education, focused explicitly on mental health prevention and community flourishing via One Health integration.

The EU BEACON action responds directly to a foundational premise of this dissertation: the need to reconfigure psychiatric and public health systems not merely through clinical interventions but via proactive, socially embedded, and ethically grounded education. Mental health vulnerability, particularly in younger populations, is profoundly shaped by structural, ecological, and pedagogical conditions (Patel et al., 2018; Horton, 2021; WHO & UNICEF, 2021). BEACON's core ambition is to promote early and equitable health education rooted in the One Health paradigm, which emphasizes the interdependence of human, animal, and environmental health (Destoumieux-Garzón et al., 2018). By targeting middle and high school educational environments, the Action provides the necessary scaffolding to cultivate resilience, shared responsibility, and critical awareness long before mental health crises materialize or become institutionalized within the coercive logics this thesis critiques.

Scientifically, BEACON is structured to address health inequalities and knowledge asymmetries by deploying AI-powered educational technologies, immersive simulation tools (VR/AR), and evidence-based curricula co-developed with local communities, schools, and clinical partners. These instruments not only enhance accessibility and engagement (particularly for students from under-resourced backgrounds), but also align with WHO and UNESCO mandates for learner-centered and rights-based education in health (World Health Organization, 2021; UNESCO, 2022). Technologically mediated pedagogy is applied not as a neutral delivery channel, but as an actively shaped, ethically governed environment fostering global citizenship, cross-cultural empathy, and systemic thinking (Schnall et al., 2020). The model incorporates continuous evaluation cycles,

teacher training, Short-Term Scientific Missions (STSMs), and cross-national collaboration, ensuring practical skill-building and applied knowledge generation.

The mental health component is central. Education on emotional regulation, healthy habits, ecological awareness, and community solidarity, delivered in structured, context-sensitive formats, serves not only as prevention but as cultural shift. By embedding shared decision-making, relational intelligence, and co-produced knowledge into daily learning, BEACON embodies the very paradigm this dissertation argues is essential: moving from reaction to preparation, from domination to dialogue, from pathology to potential. These interventions, if institutionalized across EU and global settings, carry the promise of structurally reducing the burden of psychiatric disorders by directly addressing upstream social determinants (Marmot et al., 2008; Kessler et al., 2005).

This COST Action also provides an infrastructural pathway for international collaboration across hospitals, schools, universities, civil society organizations, and public authorities. This aligns with the EU research and innovation agenda, which emphasizes interdisciplinary coordination, open science, and actionable impact (European Commission, 2020). BEACON is positioned to deliver precisely this: an operational model that transforms education into both a right and a responsibility, through scientific rigor, equity, and systemic design. The model's scalability ensures future applications in health emergencies, climate response, post-conflict recovery, and education in extreme settings, including those targeted by EU and global humanitarian frameworks.

The foundation and development of BEACON, initiated and led as a result of this thesis's research-action process, is not merely a success in funding or coordination terms. It represents a transformative platform to mainstream ethical, inclusive, and scientifically robust models of health education that address the core structural failures detailed throughout this dissertation. In its four-year initial implementation period, BEACON will serve as a living laboratory for the very principles advocated in this research. It is a concrete, scalable answer to the question of how to prevent coercion, medical violence, and epistemic injustice, not only in psychiatry, but in society at large.

3.2.8.2 Climate and mental health and youth digital mental health cost actions

The alignment of this dissertation's action-research trajectory with two other recently funded European COST Actions, CA23153 *Digital Mental Health for Young People* (YouthDMH) and CA23113 *Climate Change Impacts on Mental Health in Europe* (CliMent), constitutes a significant result in itself. These actions, both rooted in a growing transdisciplinary acknowledgment of the need for structural change in mental health systems and global public health coordination, further validate and extend the impact of the EU BEACON initiative. Through direct involvement in both YouthDMH (as task force leader on best practices) and as an active member in CliMent, this research not only advances empirical understanding but also contributes materially to the development of internationally coordinated responses to planetary health threats and psychosocial risks.

The YouthDMH COST Action addresses an urgent societal and public health imperative: the documented deterioration of mental health among younger generations across Europe (European Commission, 2023). The Action is structured to explore, evaluate, and implement the responsible use of digital technologies in supporting youth mental health, from early awareness to large-scale intervention. The inclusion of participatory methods and the prioritization of youth and marginalized voices in the co-creation of digital mental health strategies aligns directly with the

foundational principles of shared decision-making, dignity, and ethical innovation emphasized in this dissertation. It also mirrors BEACON's goals of promoting early engagement, personalized learning, and structural empowerment through educational systems. As task force leader on best practices within YouthDMH, this dissertation's author contributes specifically to identifying and formalizing evidence-based, context-sensitive approaches to integrating digital mental health tools across education, healthcare, and social sectors, with strong attention to implementation fidelity and social inclusion (Rickwood et al., 2019; Hollis et al., 2021).

Parallely, the CliMent COST Action brings into sharp focus the growing but still under-theorized intersection of climate change and mental health. Its four coordinated working groups cover impact assessment, coping strategies, short-term interventions, and long-term sustainability, all of which converge with BEACON's multi-scalar systems-thinking framework. CliMent recognizes that climate-induced ecological stressors, such as heatwaves, displacement, food insecurity, and biodiversity loss, carry profound psychiatric and psychosocial consequences (Berry et al., 2010; Cianconi et al., 2020). This research has consistently advanced the claim that mental health must be treated not in isolation but as embedded within environmental and political ecologies, and that community-based, educational, and resilience-building responses offer the only scientifically valid and ethically acceptable way forward (Baum & Fisher, 2014; WHO, 2021).

The triangulation of these three EU COST Actions, BEACON, YouthDMH, and CliMent, constitutes a robust networked infrastructure for both scaling and deepening the findings of this dissertation. This integration provides a pathway to long-term policy transformation, educational system reform, and the development of scientific frameworks capable of addressing the complexity and urgency of global mental health challenges. From One Health education in schools (BEACON), to technological innovation with youth (YouthDMH), to planetary-scale threat response (CliMent), the alliance of these COST Actions reflects an emergent paradigm: systemic prevention, collective accountability, and bioecological convergence (Frumkin et al., 2017; Costello et al., 2009).

This coordination is not merely administrative, it is epistemological. It allows for the construction of a shared scientific and institutional language across disciplines, which supports implementation research, ethical design, and continuous feedback loops grounded in real-world needs. Furthermore, the building of alliances, transnational trust, and participatory infrastructures is itself a fundamental result of the action-research process. Each Action provides critical levers of support to the others: BEACON's educational platform fosters early prevention and community literacy; YouthDMH advances technological scaffolds for engagement and individualized support; and CliMent creates the evidence base and political urgency to frame these actions within planetary health imperatives.

In this way, the thesis transcends individual data points or bounded pilot studies to contribute to a broader reorganization of knowledge production, service delivery, and ethical responsibility. It joins a coalition of researchers, educators, clinicians, and affected communities working across Europe and beyond to build systems of care that are preventive, participatory, and structurally sound.

3.2.8 The results of violence suffered itself

Chronic exposure to interpersonal violence, especially within intimate and familial relationships, produces cascading effects across neurobiological, psychological, and moral-emotional domains. From the period following Rome after Trieste, the accumulating stress from the violence inflicted by a spouse and emboldened by a complicit circle of enablers resulted in a progressive

disintegration of cognitive clarity, social functioning, and bodily resilience. This is consistent with clinical findings that sustained psychological trauma leads to dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis, hippocampal shrinkage, and loss of prefrontal regulatory functions, which compromise emotional self-regulation, memory integration, and moral decision-making (Teicher & Samson, 2016; McEwen & Morrison, 2013). The consequences were not isolated to the direct victim: over time, effects became increasingly evident in the children, who displayed blunted empathy, emotional detachment, and poor moral development, phenomena well-documented in children exposed to household adversity and coercive environments (Shonkoff et al., 2012). Furthermore, the societal and clinical indifference toward the situation compounded the damage. For instance, when a psychiatrist's spouse, informed of the abuse, recommended not a trauma-informed intervention but instead a standard boarding school, disconnected from the psychological context, this reflected a profound failure in recognizing the roots and continuity of violence. The opportunity to remove the children to a safe, structured, high-quality environment, potentially supported by an extended family member, was tragically lost, representing a textbook example of secondary victimization and institutional betrayal (Smith & Freyd, 2014). Such failures are not only moral and strategic, they are neurological, structural, and epigenetic, leaving lasting imprints on body and mind. Years later, with no real accountability or intervention, the effects continue: alienation, developmental delay, toxic stress cycles, and deteriorated capacity for secure attachment and reasoning, all of which have been extensively documented in trauma literature.

Table 75 - Pathways from violence suffered to long-term damage in victim and children

Domain Affected	Pathway from Violence Suffered	Impact on Victim	Impact on Children
Neuroendocrine	HPA axis dysregulation → chronic cortisol elevation	Fatigue, memory loss, immune suppression	Impaired stress regulation, delayed brain maturation
Neurological	Repeated trauma → hippocampal and prefrontal cortex atrophy	Dissociation, emotional blunting	Emotional dysregulation, difficulty learning empathy
Moral-emotional	Coercive control, gaslighting → collapse of trust, fear	Guilt, shame, fractured identity	Moral detachment, resistance to constructive feedback
Psychosocial	Social betrayal → loss of support, isolation	Depression, hopelessness	Externalized aggression, self-centered coping strategies
Educational	Systemic neglect → failure to remove from traumatic environment	Despair, career derailment	Missed developmental windows, educational underachievement
Epigenetic	Trauma exposure → changes in DNA methylation (e.g., NR3C1, FKBP5 genes)	Increased vulnerability to anxiety, metabolic syndrome	Inherited stress sensitivity, intergenerational trauma transmission
Institutional betrayal	Mental health professionals ignoring or downplaying abuse	Re-traumatization, loss of faith in care systems	Lack of protective modeling, belief in false authority

The following article explores the reality of the first episode of physical violence endured by the researcher, that lead to years of hatred, loathing, threats, defamation that enabled and instrumentalized coercive psychiatric intervention to further harm, discredit and silence, resulted in losing it all except my live, despite best efforts by the abusers to the contrary.

The destructiveness of xenophobia

Enric Garcia Torrents

The author is a cultural and biomedical anthropologist, M.Sc. Medical Anthropology Research Center, Universitat Rovira i Virgili, Spain, Institute for Globally Distributed Open Research and Education (IGDORE) <https://research.enricgarcia.md>. Email: enric.garcia@urv.cat

ABSTRACT: This paper expresses profound appreciation for the tireless efforts of individuals and institutions dedicated to elevating the efficacy and ethicality of healthcare delivery. A personal narrative illustrates the systemic shortcomings that necessitate urgent reforms, particularly in light of the devastating intersection of inadequate medical care and domestic violence.

KEY WORDS: Violence, migraine, discrimination

Years ago, an unfortunate personal experience involving an incapacitating migraine resulted in an unwarranted threat of involuntary institutionalization. This incident and its long lasting consequences underscores the critical issue of inadequate recognition and management of both physical and mental health conditions, exacerbated by the potential for domestic and family abuse to masquerade as legitimate concerns.

Amidst the challenges of post-partum anxiety and the demands of daily life following the arrival of our second son, a healthy baby; our family, my partner and I kept on confronting the harsh realities of xenophobia and racism embedded within societal structures, exacerbated by disapproval of our marriage and presence in the country from even own close family relatives. Our experiences, though personal, reflect a broader truth faced by many worldwide. Despite our efforts, the stigma of being perceived as outsiders in a society tainted by prejudice and exploitation weighed heavily upon us, intensifying with the new addition to our family. Our struggles, emblematic of those marginalized and overlooked, exposed the pervasive culture of silence and indifference enabling discrimination to flourish unchecked. Still too often silenced by

shame and fear, we found ourselves trapped in a suffocating web of lies and veil of legitimacy, the knot of despair tightening around our necks. Yet, through our pain, we found resilience, determined to reclaim our dignity and amplify the voices of others silenced by oppression. Our experience, though marked by adversity, serves as a testament to the enduring spirit of those who refuse to be reduced to statistics or stereotypes, striving instead for justice and recognition of a shared humanity.

The tendency to ignore our concerns and real problems, leading to protracted suffering, extends beyond the realm of trained medical professionals and encompasses social workers and even individuals lacking specialized training, who can inadvertently become contributors to a cycle of pain and despair. Furthermore, the presence of domestic violence can complicate and manipulate the institutionalization process, potentially leading to further abuse and harm.

The one simple avoidable mistake on a test used the wrong way, and my own voice denied. Years of pain afterward, on top of the one already suffering. Damage imposed on me and my loved ones, those who needed me healthy and strong.

This message serves as a clarion call to those actively combating the insidious practices of medical malpractice and domestic violence. While the ramifications of my ordeal extended significantly to my loved ones, I wish to emphasize the following key points:

- The inherent limitations of Transcranial Arterial Cerebral (TAC) scans in detecting migraines: Due to their inability to capture the dynamic aspects of brain activity, subtle neurological shifts, and the subjective experience of pain itself, TAC scans are inherently incapable of identifying both silent and typical migraines. Consequently, accurate diagnosis necessitates rigorous clinical evaluations or the deployment of more advanced imaging modalities.
- The paramount importance of meticulous diagnosis, particularly in mental health assessments, with heightened awareness of potential domestic violence: My lived experience, encompassing chronic migraines attributed to overwork and a potentially contusive head injury, exemplifies the crucial need to objectively discern verifiable facts from subjective interpretations and emotional narratives. This discernment should not be left to chance but must be guided by established, evidence-based best practices within the medical field, coupled with sensitivity to the complexities of domestic violence and its potential to manipulate diagnoses and narratives.
- The urgent need for comprehensive healthcare systems that recognize and address domestic violence: My personal case shines a stark light on the alarming potential for healthcare systems, ironically, to become perpetrators of further illness rather than facilitators of genuine healing and effective solutions. Moving forward, a collective effort is imperative to establish a

healthcare system that prioritizes precision in diagnosis, compassionate care, and, ultimately, the optimal well-being of all individuals, with specific protocols and training in place to identify and combat domestic violence within the medical setting.

My story unveils a harrowing truth: systems meant to help can become sources of harm when they fail to act with integrity and care. We deserve better! We need a society where all institutions, from healthcare to social services and law enforcement, prioritize accurate assessments, compassionate intervention, and the well-being of all. This is not just my story, it's a collective reckoning. Inaccurate assessments and negligence can devastate families, leaving emotional scars, financial burdens, and disrupted care in their wake. They sow fear, silencing voices and discouraging essential help-seeking, ultimately jeopardizing our collective well-being. Let's join hands and demand more. We need systems where professionals across all fields work with dedication, honesty, and unwavering commitment to best practices, fully aware of the devastating consequences of carelessness. Together, we can build a society that truly heals, protects, and empowers.

Dedication

This opinion piece is dedicated to my loving wife, to our cherished boy and girl, and to all who endure the oppressive structures of discrimination and exploitation, disguised as support services. In the face of adversity, you stand as pillars of resilience, challenging the entrenched biases of society and striving for a more just and equitable world. Your strength inspires us all to speak out against injustice and to uplift those silenced by oppression. Together, may we continue to fight for a future where every individual is valued and respected, regardless of race, ethnicity, or background. Thanks to the editors for publishing it, and all professionals and advocates who work for true justice and health, unburdened by prejudice, wilful ignorance, corruption, malpractice and hatred.

3.3 Chapter conclusion: amplifying experience, diagnosing the system

The results presented in this chapter emerge from a complex and multi-scalar research architecture grounded in medical anthropology, biocultural anthropology, medicine, biology, and action-research principles. Through surveys, fieldwork, interviews, observation, collaborative events, international missions, and direct engagement in institutional reform processes, this body of work elucidates the multifactorial and deeply systemic nature of coercion, violence, and malpractice in psychiatric and psychosocial care. The findings are not isolated episodes or anecdotal instances; rather, they constitute an integrated, empirical demonstration of how structural and interpersonal abuse is legitimized, perpetuated, and normalized within dominant mental health systems, systems which often suppress dissenting voices, marginalize survivors, and obscure failures under clinical justifications that lack both scientific validity and ethical legitimacy.

Thematically, the results corroborate the thesis' central argument: that shared decision-making, autonomous medication management, and human rights-based care are not optional reforms but essential imperatives to prevent systemic degradation and restore public trust in health institutions. The qualitative richness of lived experience, documented through first-person accounts, professional collaboration, and extended observation, is shown to be indispensable for understanding the real consequences of coercion, the epistemic corruption in psychiatric labeling, and the role of socio-political structures in enforcing silencing mechanisms. The chapter demonstrated how dialogical, trauma-informed, and transdisciplinary methodologies can generate not only data but protective mechanisms and systemic resilience.

Across settings, from Spanish hospitals to Trieste's legacy of democratic psychiatry, from the EU COST networks to the digital spaces of open science, this work shows how entrenched hierarchies can be both challenged and transformed. The strategic coordination of research actions such as BEACON, FOSTREN, ReMO, YouthDMH, and CliMent, all described as integral components of the results, confirms that knowledge generation can be embedded within networks of ethical change and structural reform. Far from a passive critique, this chapter serves as an active intervention, both scholarly and civic, in the reconfiguration of mental health systems toward equity, transparency, and restorative accountability.

In direct relation to the dissertation's overarching action-research purpose to help better the systems studied, the chapter shows how the researcher operationalized the core theoretical principles laid out in earlier sections by anchoring them in real-world interventions, measurable outputs, and collaborative achievements. The connection between domestic violence, institutional betrayal, medical coercion, and structural injustice has been exposed not only as a pattern of harm but as a preventable and reversible outcome, provided scientific and civic courage prevail. These results are a call to action, scientific, legal, and educational. They validate the necessity and feasibility of a coordinated shift toward One Health Education as a foundation for human dignity and planetary sanity. The evidence is clear. Now, we need to keep on working.

Chapter 4: Findings and discussion

Summary: This chapter presents the core empirical findings of a five-year ethnographic investigation into psychiatric care, institutional violence, and systemic betrayal of patient dignity within Spain and affiliated European contexts. Drawing from participant observation, digital ethnography, survey data, legal analysis, and direct experience, the chapter documents how coercion, rather than care, functions as the organizing principle of mental health services. It reveals that consent is often procedural and hollow, while treatment decisions are dictated by inflexible diagnostic scripts and family pressures rather than contextual understanding or shared decision-making. The fieldwork exposes how professionals, patients, and families are all entangled in a structurally violent system that fails to deliver on its ethical promises, eroding trust and amplifying harm. Chapter 4 also highlights the epistemological failures of psychiatry's reliance on genetic determinism and its neglect of trauma, social conditions, and relational dynamics. Despite systemic failures, the chapter affirms that recovery is possible through relational, rights-based, and contextually responsive care. It outlines concrete, evidence-backed pathways forward, emphasizing safety, dignity, and coordinated support, as the necessary basis for ethical and effective psychiatric practice. The chapter concludes that only a complete reorientation of psychiatry's conceptual foundations and operational norms can restore justice, prevent further harm, and uphold constitutional and human rights.

4.1 Findings: institutional violence, betrayal of duty to care and protect

This chapter presents the central findings of a five-year ethnographic investigation into psychiatric practice, patient experience, and systemic coercion in Spain and affiliated international networks. Drawing from participant observation, first-person witnessing, legal analysis, and survey data, the results confirm that the mental health system, as it currently operates, routinely fails to protect the dignity, autonomy, and well-being of those it claims to serve. Instead, it perpetuates an institutional apparatus of discretionary violence that is epistemologically outdated, procedurally opaque, and structurally misaligned with the stated goals of recovery, public health, or rights-based care.

The fieldwork was situated in diverse settings, community mental health teams, hospitals, primary care units, family interventions, emergency services, academic institutions, peer-run spaces, and international forums, spanning multiple countries but concentrated in Spain. It involved interactions with key actors: patients, relatives, nurses, psychiatrists, psychologists, general practitioners, social workers, legal professionals, administrators, media, and public officials. Within these settings, this thesis observed patterns of routinized coercion, dehumanizing procedures, and epistemic violence in both formal and informal interactions.

The field confirms that psychiatric interventions in Spain are not organized around shared decision-making (Slade, 2017), despite its recognition as a basic clinical and ethical standard. Instead, they are shaped by preconfigured diagnostic routes and closed pharmacological algorithms that offer no meaningful choice or informed consent. Consent, when sought, is often reduced to the procedural minimum, rendered meaningless by asymmetries of information, fear of abandonment, and the lack of viable alternatives. In many cases, medication is imposed or presented as a condition for access to social services or protection, particularly in the context of family conflict or institutional neglect.

This thesis documents that coercion is not an exception to psychiatric care, it is its organizing principle, especially for those deemed noncompliant or diagnostically "severe." The imposition of treatment without context-sensitive justification results in a cascade of long-term harms: functional decline, metabolic deterioration, cognitive blunting, and the loss of trust in all care systems. While framed as therapeutic necessity, these interventions are often triggered by institutional fatigue, administrative protocols, or family pressures, not evidence-based evaluation of individual need. Families, in particular, exert substantial influence over psychiatric decisions, often without scrutiny, even when dynamics of violence, abuse, or control are present (Drew et al., 2011). These roles remain largely invisible in official documentation, Yet, their effects are profound.

Practitioners, too, experience structural violence. Field data confirms that professionals who attempt to resist coercive norms or implement rights-based care are often isolated or sanctioned. Many report internal conflict, burnout, and institutional obstruction. Yet, the critical decision points, diagnosis, prescription, institutionalization, remain in the hands of these same professionals. These decisions hold power. They mark individuals in records, restrict liberty, and define the scope of future agency. The ethical demand is therefore clear: no diagnosis, intervention, or deprivation of liberty should occur without rigorous justification, and without the proactive inclusion of the individual's perspective and history.

The findings reveal a striking phenomenon: trust is repeatedly fractured at every point in the clinical trajectory. Individuals arrive to services not merely with symptoms, but with broken contexts, violence, exhaustion, grief, or betrayal. Their first need is recognition, not regulation. Yet, the default approach is pathologization: identifying behavior to be controlled rather than context to be understood. Too often, patients are profiled and treated according to abstract categories, typologies disconnected from their real conditions, often derived from cultural or gendered assumptions.

In institutional settings, weight gain is frequently monitored as a sign of compliance, particularly with depot antipsychotics. Thinness becomes suspect; somatic expression of autonomy is reinterpreted as symptom (Davidson & Roe, 2007). Conversations that could clarify context, about trauma, heartbreak, economic distress, religious crises, sleep deprivation, or domestic violence, are rarely initiated. The result is not only clinical failure, but structural abandonment.

This thesis contends that there are no legitimate psychiatric "alternatives" to coercion, only better options, which must be ranked, available, and delivered as part of standard care. These include context-aware pharmacology, trauma-informed therapies, community-based supports, crisis peer spaces, and social coordination for housing, income, and protection (World Health Organization, 2021). These are not luxuries. They are the minimal standards for ethically acceptable care. Psychiatric prescriptions must be approached as one would fit corrective lenses: precisely, reversibly, and transparently. Every individual deserves clarity on what is being done to their body and mind, and why.

The findings also document that even minimal humane gestures, a moment of listening, a phone call to a family member for support, or the offer of a safe bed, can shift the entire trajectory of a crisis. Where coordination with social services was attempted, the outcomes were more stable, less traumatic, and less costly. In contrast, the cost, in suffering and economic terms, of forced hospitalization, long-term disability, and pharmacological overreach remains incalculable. It is not simply inefficient: it is a form of iatrogenic structural violence with legal, moral, and intergenerational consequences. Psychiatric care unfolds within a choreography of betrayal and

truncated trust, often initiated well before clinical contact. Patients often arrive already carrying the weight of abandonment, overwork, domestic violence, or generational precarity. Many were brought in by relatives unable or unwilling to remain present, or by professionals misled by appearances, unfamiliar with the patient's language, or incentivized to pathologize behavioral divergence. In this context, the first and most urgent ethical act is to not betray again, to refuse the automatic repetition of systems that negate the will to live under the pretext of professional concern. Trust, once fractured, demands rigorous care in its reconstruction, not surveillance, not sedation, not silence.

At stake is the very meaning of care. What the findings expose is not merely a crisis of efficiency or evidence, but a crisis of moral orientation: a system that too often punishes rather than helps, silences rather than listens, injures while claiming to heal. The failure is not theoretical, it is enacted, patient after patient, diagnosis after diagnosis, prescription after prescription. Repair will not begin until the foundational taboos of psychiatry are named, dismantled, and replaced by operational protocols based on listening, precision, coordination, and real consent. That requires much more coordinated work to shift the balance and make impossible to stop the required cultural shift to ensure health and sanity prevails, instead of harm and killing perpetrated by any means.

4.2 Potential paths forward

This section distills the main conclusions from the personal and collective evidence base gathered throughout the thesis research, emphasizing the systemic patterns of harm and the plausible, evidence-backed solutions that must be adopted as institutional standards. The personal experience of institutional violence, far from anecdotal, reveals structural mechanisms that reproduce psychiatric harm through professional neglect, domestic complicity, policy inertia, and epistemic misclassification. What emerges is not a set of isolated failures, but a coherent machinery of exclusion, one whose operation is legitimized through pseudo-clinical language and deeply embedded cultural taboos against dissent, refusal, and autonomy.

Among the most recurrent and damaging features identified is the reliance on coercion in the absence of safety infrastructures. Individuals subjected to forced psychiatric treatment are overwhelmingly those who lack safe places to rest, to speak, or to recover. In many cases, this results from structural deprivation: insecure housing, exposure to violence, precarity, and institutional abandonment. The thesis confirms that the most effective psychiatric intervention begins not with a prescription, but with a safe bed, in a safe house, within a safe street, in a city designed for human well-being, not reactive policing. These are not metaphors. This is the baseline: dignified living conditions as a prerequisite for any ethical or effective health response.

Scientific literature already affirms that access to stable housing significantly reduces hospitalization rates, emergency admissions, and psychiatric relapses. Furthermore, communities designed along the principles of "blue zones", with walkability, clean air, shared green space, access to nutrition, community cohesion, and slower pace, demonstrate improved cognitive and emotional outcomes across populations, particularly among the most vulnerable. Yet, such environmental determinants remain ignored by psychiatric services, which often operate in degraded hospital infrastructures disconnected from the broader ecosystem of health.

The personal experience contributing to this thesis documents the collapse of these systems from within. Forced drugging, administered without informed consent, in the context of domestic abuse,

false allegations, and institutional collusion, resulted in long-term cognitive, social, and professional damage. Reports made by professionals with ethical concern were erased. Requests for review, alternative approaches, or basic protection were ignored. These were not isolated incidents, but the norm across services that failed to distinguish between care and control. This is not a failure of individual goodwill; it is a failure of professional accountability, procedural rigor, and structural design. What then emerges from the findings is a clear path forward, built not on idealistic reform but on known, evidence-backed practices. These include:

- Shared decision-making as default protocol, not aspirational exception (Slade, 2017).
- Integrated social coordination ensuring that no person is discharged into homelessness, abuse, or destitution (World Health Organization, 2021).
- Trauma-informed responses where the first task is to listen, not medicate, and to map causes rather than mask symptoms
- Operational safeguarding against domestic abusers posing as caregivers, with clear protocols to verify relational integrity before enacting psychiatric intervention
- Community investment in prevention: public housing, education, digital support tools, green infrastructure, and legal empowerment as the true front line of psychiatric protection

These pathways are cost-effective, evidence-based, and grounded in human rights. They are not future reforms, they are existing models being withheld from implementation by inertia, miseducation, and institutional resistance. This thesis confirms their relevance, viability, and urgency. If adopted, they would drastically reduce forced hospitalizations, eliminate many iatrogenic injuries, and restore the dignity and capacity of tens of thousands. If ignored, the cycle of trauma, punishment, and decay will persist, under the guise of care.

4.3 The current wasting of lives requires us all coordinated

The current mental health strategy in Spain, as articulated in the *Plan de Acción de Salud Mental 2022–2024*, acknowledges the urgency of suicide prevention, the integration of psychosocial support, and the expansion of professional capacity. However, this plan reveals a profound structural contradiction: it allocates substantial resources to downstream interventions, emergency response, pharmacological containment, and clinical expansion, while underinvesting in the upstream determinants of mental health, namely education, social cohesion, housing, and early-life prevention

This inverted investment pyramid is not a technical oversight. It is a political artifact, rooted in short-termism, biomedical dominance, and institutional inertia. Mental health professionals interviewed and engaged during this thesis, including senior public health administrators in Catalonia, concur: public funding for preventive, developmental, and educational interventions remains marginal compared to the massive public expenditure dedicated to drug subsidies, psychiatric hospital maintenance, and crisis policing. The result is a structurally iatrogenic system, one that waits for breakdown before intervening, and that does so in ways that often reproduce the conditions that caused the crisis in the first place.

This diagnosis is shared internationally. The WHO QualityRights initiative calls for a "fundamental shift in mental health systems," explicitly rejecting coercive, medication-first approaches in favor of

person-centered, rights-based, and community-integrated care models (World Health Organization, 2021). Similarly, global sustainability frameworks, from the UN Agenda 2030 to the European Green Deal, emphasize the ecological and economic irrationality of systems that overconsume finite resources while underinvesting in human development. The same logic applies to psychiatry: austerity is expensive when it undermines human potential, and coercion is inefficient when it depletes trust, capacity, and health.

Yet, the political contradictions persist. While suicide prevention campaigns gain visibility, the broader structures that produce psychic exhaustion, precarity, isolation, domestic violence, climate anxiety, and institutional betrayal, remain largely unaddressed. Educational systems remain underfunded and unprepared to support students' cognitive and emotional development. Nutritional programs are insufficient. Urban environments are congested and disjointed from natural cycles. And psychiatric discourse still stigmatizes those who break down under such pressure, diagnosing them rather than examining the structure itself.

What this thesis demonstrates is that the true cost of coercion is not just moral, it is material, generational, and planetary. Coerced psychiatry does not just suppress behavior, it suppresses citizenship, participation, and innovation. It dulls agency. It shortens lives. It precludes collaboration. In contrast, rights-based approaches grounded in early support, education, and social solidarity unlock resilience and creativity, at individual and societal levels. These are not vague ideals. They are operational principles, documented and testable.

The challenge is not lack of knowledge, it is conflict of models. The dominant model in Spain and most high-income countries remains anchored in vertical authority, expert dominance, and diagnostic standardization. The emerging model, supported by international frameworks and corroborated by BEACON's scientific action, emphasizes mutual accountability, participatory decision-making, ecological reasoning, and global-local coherence. These models are not easily reconcilable. One treats the patient. The other builds the conditions for health.

Thus, a conflict is inevitable unless realignment occurs. This thesis identifies three strategic levers to preempt this conflict and redirect mental health toward sustainable, rights-based outcomes:

1. Mandatory public investment in school-based mental health education, starting from early childhood, supported by community caregivers, trained teachers, and peer-led models, with full integration of physical health, relational skills, and nutrition.
2. Universal access to safe housing and green urban environments, including protected recovery homes, coordinated by municipal and regional infrastructures as a mental health policy, not as welfare side programs.
3. Legally enforceable mechanisms of accountability within psychiatric services, including transparent outcome audits, participatory planning, and independent oversight capable of protecting users' rights and intervening in structural malpractice.

These are minimal operational reforms already backed by science, ethics, and comparative experience. The real question is not feasibility, but political will. If implemented, these reforms would prevent enormous downstream costs, economic, social, and existential, and offer the possibility of what psychiatry claims to seek: healing. If ignored, the system will continue to fracture, trapping both practitioners and patients in a cycle of failure, resentment, and chronicization.

In this historical moment, we are not short of knowledge, we are short of courage. The findings of this thesis demand that we reverse the pyramid, reclaim prevention, and redirect the machinery of care from coercion to cooperation. The longer we delay, the higher the cost, not only for individuals, but for society itself. Beyond official plans and rhetorical commitments, the ethnographic findings of this thesis point to a much darker institutional reality. Across wards, outpatient settings, and administrative centers, daily life for psychiatric users is often shaped by environments of normalized neglect. Professionals remain physically present but emotionally and intellectually absent, relegated to supervisory positions that reduce their task to observation and containment. The therapeutic spaces themselves, often reduced to tables, corridors, and waiting areas, become zones of time-wasting rather than time-repairing, with patients asked to repeat childish crafts or remain idle while their actual needs remain unaddressed.

What the research documented is a profound waste of human potential, both among those subjected to psychiatric regimes and among many of the professionals tasked with their care. At times, the work culture appears so static and risk-averse that metaphorically, and, in some institutions, almost literally, a crane would be required to dislodge professionals from their postures of institutional passivity. The system fails not for lack of knowledge or resources, but due to the entrenchment of routines and symbolic roles that serve more to protect the institution from criticism than to protect the patient from harm.

In multiple cases analyzed, patients were left without meaningful engagement, structured rehabilitation, or even basic relational support. The result is a process of institutionalization that destroys life trajectories: interrupting education, damaging families, reducing social networks, and locking individuals into stigmatizing profiles from which it is almost impossible to emerge. These are not isolated failures. They are the direct result of a mental health system that still treats coercion, surveillance, and sedation as default forms of care.

The culture of pathologizing autonomy is especially pronounced in these contexts. Patients who question their treatment, ask for second opinions, or request discontinuation of medication are routinely labeled as "lacking insight," "noncompliant," or "at risk." The professional response is often punitive: increasing medication, isolating the person, or intensifying the diagnostic label. Meanwhile, practitioners are rarely challenged, even when their actions clearly contradict ethical standards or empirical evidence. This is not medicine, it is a regulatory regime disguised as therapy, operating with minimal accountability.

The consequences are predictable and devastating. Instead of restoring capacity, the system erodes it. Instead of accompanying people in crisis, it encodes their suffering into closed files. Instead of building relational networks, it atomizes. It is not just that lives are lost; it is that the lives that continue are shaped into patterns of despair, marginalization, and abandonment, often with institutional sanction. This is not merely a medical issue. It is a crisis of civilization, of what kind of future we are willing to tolerate for those who struggle, grieve, break down, or dissent.

This thesis finds no justification, scientific, ethical, or economic, for continuing this model. It is neither evidence-based nor cost-effective. It does not reduce suffering. It amplifies it. It does not deliver care. It distributes harm. And it does not build health. It administers stagnation. Reversing this trajectory is not a question of resources but of values. The findings show clearly: change is not only necessary, it is long overdue. The invisible architecture of abandonment in mental health systems is heartbreaking, betraying its purpose all along: the structural, cognitive, and affective

conditions that lead a person not only to be destitute, but to be made destituted, placed in a position of total dependency without trust, recognition, or care. These are not merely the failures of medication regimens, waiting lists, or diagnostics. They are failures of human contact, of early intervention, of educational imagination, and of a society that systematically fails to see the other, the singular, the already harmed, except as a burden or liability. In the fieldwork, the observational spaces, from residential homes to acute wards, often resembled a maritime emergency in slow motion: survivors afloat on minimal support, others deflating quietly beneath the surface, their signals unrecognized or misinterpreted as pathology rather than exhaustion. The flotation line, in this sense, became the threshold of rehumanization: to notice what is sinking before it disappears.

Yet, most of the time, those closest to sinking were those least visible to the system. Professionals, though trained and sometimes deeply motivated, remained trapped within walled premises, literal and institutional, unable to act due to risk protocols, staffing shortages, or bureaucratic inertia. Outside those walls, families fractured under the weight of unsupported care, economic instability, or transgenerational trauma. Meanwhile, many users carried their own misdiagnoses, unprocessed abuse histories, or silent grief through years of ineffective or harmful treatment, reduced to cases instead of people. To set sail toward healing is not a poetic luxury. It is a clinical and social imperative. It requires the removal of systemic anchors, the routine suspicion of autonomy, the professional deference to outdated models, the logistical absurdity of not acting early because a crisis has not Yet, occurred. The "no" to further harm must be operative, respected, actionable. And the "yes" to life must not require submission or passivity, but a setting in which dignity is presupposed, not negotiated. From this ethnographic vantage, what is needed is not merely alternatives to coercion, but a complete reorientation of purpose: to ensure that every individual, no matter how chaotic their trajectory, has a right to reassemble the pieces of their life under their own terms, with support, not control. This is neither utopian nor sentimental. It is what good medicine already knows: time, recognition, and accurate listening save lives. So do shelter, quiet, meals, and non-violated space.

Some of the most remarkable moments in fieldwork came from what professionals themselves said they wished they could do, but felt unable to, stay longer, listen deeper, protect rather than medicate, invite rather than restrain, learn rather than diagnose. These desires must not be archived as professional regrets. They must be systemically enabled. In short, the findings converge on a single truth: if we do not act on the needs we know exist, we become perpetrators of the very harm we are mandated to prevent. The flotation line must be raised. No more silent sinkings.

4.4 Rewriting the frame: beyond genetic determinism and toward structural commitment

The findings from this fieldwork and narrative analysis unequivocally indicate that the current psychiatric system, both in its conceptual foundations and operational behaviors, remains deeply entangled with outdated notions of genetic determinism, pathologizing essentialism, and eugenic residue. In multiple contexts across Spain and Europe, participants and professionals alike echoed a pervasive reductionism: the assumption that "mental illness" is rooted primarily or exclusively in immutable, inherited traits. While genetic research has Yet, to demonstrate conclusive biological markers with sufficient predictive power for most psychiatric diagnoses (Kendler, 2020; Sullivan et al., 2018), this deterministic framing continues to justify coercion, diagnostic inertia, and the systemic deprivation of autonomy.

This work presents strong empirical support that, in lived reality, neither patients nor practitioners benefit from rigid biological narratives that sideline context, trauma, or meaning. As one participant put it during observation in a Catalan hospital unit: "we no longer care if it's genetic; what we care about is how to live." This resonates with evidence from trauma-informed care research, which stresses that framing distress in terms of life experiences rather than pathology leads to better outcomes and fosters therapeutic alliance (Sweeney & Taggart, 2018). Such a shift demands not only epistemological reform, but structural responsibility, where systems must guarantee the conditions for dignity, healing, and non-violence.

Throughout our research, the urgency of alternatives gave way to a deeper insight: what is needed is not merely "alternative models" but primary best practices, ranked and contextualized based on evidence and human preference, not imposed protocols. As illustrated by the WHO QualityRights initiative (World Health Organization, 2019), and affirmed in Spanish field interviews, shared decision-making, personalized support, and respect for legal capacity are not optional, they are ethical and clinical imperatives. The current reality, however, too often inverts these principles. Decisions are made without consent, non-pharmacological options are either absent or unavailable, and systemic disregard of environmental, familial, or social causes renders the entire apparatus of care unresponsive (Dawson et al., 2022).

Historical continuity between past abusive taxonomies -feeble mindedness, idiocy, imbecility, degeneracy- and modern diagnostic practices must not be overlooked. The nomenclature may have changed, but the operational effects, social death, forced treatment, confinement, and life-course exclusion, persist in subtler forms (Rose, 2019). When young children are profiled for lifelong surveillance, when families are overridden by medical fiat, and when trauma is mistaken for disorder, psychiatry operates not as a healing profession, but as a disciplinary mechanism. Field data reveals how easy it is for institutionalized individuals to become objectified, de-personalized, and perceived solely through the lens of their diagnosis. This phenomenon, which Erving Goffman described as the "mortification of the self" in total institutions (Goffman, 1961), is not historical but ongoing. Rejecting hereditary determinism as the de facto assumption is an imperative, as well as the pretense of neurodegeneration unless drugged and treated as usual, with all iatrogenic harm and social death ensuing leading to the observable damaging of the brain, used as if evidence of that one initial premise to allow themselves to repeat the abuses over and over, not providing any way out. The very notion that one's future is biologically predetermined violates not only the UN Convention on the Rights of Persons with Disabilities (CRPD) but the foundational principles of medicine itself: to respect the patient, to do no harm, and to provide care appropriate to the person, not merely to the label. Structural responses must instead begin with the person's needs and desires, not with the assumptions of clinicians. They must involve families, when safe and supportive, while offering mechanisms to detect, prevent, and halt abuse disguised as care. As seen in ethnographic cases in both Catalonia and Indonesia, healing occurred not in the presence of heavy protocols, but in the emergence of safe, relational ecosystems where patients were treated as competent, dignified, and socially embedded beings.

4.5 Pathways to reform: toward education, dignity, and structural sanity in mental health

The findings of this dissertation confirm that transitioning away from a psychiatric paradigm centered on genetic determinism, chronicity, and coercive control toward a biocultural model rooted in structural care, social accountability, and human dignity is not only viable, it is imperative. The evidence shows that healing is not a pharmacological event, nor a compliance outcome, but a

deeply relational, embodied, and contextually situated human process. What supports recovery is what genuinely helps the person in their real life, not what disciplines them into submission or silences their suffering. To continue violating fundamental rights under the pretext of "mental health" is to weaponize care against the very individuals it is supposed to protect. This is not a marginal failure, but a systemic pattern whereby persons labeled with psychiatric diagnoses are routinely denied their right to liberty (Art. 17), to moral and physical integrity (Art. 15), to privacy (Art. 18), to judicial protection (Art. 24), and to live a life in dignity (Art. 10) as enshrined in the Spanish Constitution. These are not theoretical breaches, they are practiced, daily, as forms of institutionalized suspension of rights, carried out without individualized proof, proportionality, or access to remedy. The result is a state of permanent exception applied to some of the most vulnerable members of society, with no temporal limitation, no adversarial procedure, and no redress. Mental health legislation, as currently interpreted and implemented, not only enables but structurally incentivizes this erosion of constitutional protections, relying on vaguely defined notions of "risk" and "incapacity" that substitute clinical authority for judicial oversight. This constitutes a reversal of the burden of proof, where the person must prove they are not dangerous, not unwell, not broken, under conditions that preclude that very possibility. It is the paradigm itself that requires correction.

To uphold the rule of law and restore trust in medicine, the state must urgently guarantee that no individual is denied autonomy, liberty, or legal agency solely on the basis of a medicalized label. This means enforcing effective safeguards, establishing procedural protections, and replacing coercive, dehumanizing interventions with models grounded in informed consent, trauma-informed care, and co-produced support. The right to live in dignity, to express distress without punishment, to be recognized as a rights-bearing subject even when unwell, must become the ethical and operational foundation of mental health practice. Anything less is a betrayal, not only of patients and their families, but of the democratic and constitutional commitments of the society itself. This dissertation is both a documentation of that betrayal and a contribution to its urgent reversal.

The findings of this dissertation compel a decisive break from coercive psychiatry and punitive welfare logics. They demand not rhetorical reform, but concrete, operational transformation of health, education, and institutional design. The structural violence evidenced here, through forced pharmacology, diagnostic erasure, and bureaucratic exclusion, is not remediable through piecemeal ethics training or superficial patient charters. It is systemic. It is encoded in the routines, incentives, and educational foundations of current clinical practice. Reparation requires structural re-foundation. This section outlines the pathways to that task, linking the empirical base of this research with the transnational institutional mandate now embodied in the COST Action CA24106, *BEACON: One Health Education and Technology*, initiated and coordinated by the author during the doctoral process.

The first pathway is epistemological and curricular. Psychiatric training must be fundamentally restructured away from diagnostic essentialism and toward relational, ecological, and rights-based knowledge. A new epistemic canon is required, one that integrates trauma-informed approaches, survivor intelligence, community-led recovery models, planetary health, and social accountability. Education cannot remain complicit in the reproduction of harm. The EU BEACON initiative addresses this need directly, building a coordinated, multi-level One Health Education system that includes mental health, digital and environmental literacy, and structural ethics as core components from early childhood to professional training. Universities, vocational centers, and clinical bodies

must be equipped to teach care as a situated, negotiated, and preventive act, not as procedural compliance to outdated medical hierarchies.

The second pathway is infrastructural. Institutions must be redesigned to enable restorative, non-coercive forms of care. This entails the creation of protected spaces for shared decision-making, family dialogue, long-term accompaniment, and conflict transformation. The evidence gathered here, and echoed across international guidelines, demonstrates that medication compliance models produce dependency, stigma, and premature death. In contrast, community-supported networks, housing-first programs, and peer-led crisis response offer measurable benefits in autonomy, functionality, and dignity. The EU BEACON framework supports pilot implementation and cross-regional transfer of such practices, linking schools, clinics, municipalities, and research nodes across Europe and beyond. This creates a living infrastructure of ethical care, anchored in local realities but coordinated through open standards and global justice principles.

The third pathway is legal and institutional. Coercive psychiatric practices, forced drugging, involuntary hospitalization, and discrediting through diagnosis, must be treated not as neutral procedures but as potential human rights violations. Legal frameworks must evolve to protect bodily and cognitive sovereignty, ensure accountability for psychiatric abuse, and guarantee access to independent advocacy and review mechanisms. Medical professionals must be held to standards of informed, dialogical, and accountable practice. The EU BEACON action, through its Working Groups and policy outreach, is positioned to contribute directly to legislative reform by consolidating evidence, developing model laws, and supporting public institutions in transitioning away from harmful paradigms. The interface between legal, clinical, and educational systems must be reconfigured to protect rather than undermine autonomy.

The fourth pathway is technological. The digitization of mental health services must not replicate the surveillance, pathologization, and diagnostic capture seen in analogue systems. Instead, digital tools must be developed as open-source, privacy-respecting, co-produced systems that enable continuity of care, participatory monitoring, and emancipatory education. Algorithms must not flag dissent or nonconformity as pathology; rather, they must learn from lived experience to support autonomy, health promotion, and epistemic justice. Within EU BEACON, ethical AI and digital mental health tools are co-designed with users, educators, and practitioners to avoid harm and foster accountability. Open science is not merely a publishing model, it is a normative stance against enclosure and a method of collaborative resilience-building.

Finally, the fifth pathway is political and cultural. The dominant paradigms in psychiatry, law, and welfare governance cannot be challenged through evidence alone. They must be displaced through coordinated public deliberation, survivor leadership, and cultural transformation. Shame, silence, and dismissal must give way to testimony, recognition, and systemic care. This dissertation, together with the EU BEACON action, stands as a collective call for institutions to renounce the epistemologies of punishment, to cease erasing those who suffer, and to embrace a future in which health is relational, education is emancipatory, and care is never confused with control. Reform is not a matter of possibility, but of responsibility. The tools, knowledge, and international support structures now exist. The implementation of better practices, grounded in dignity, dialogue, and open coordination will be sooner than later a reality. Work is ongoing.

Among the most urgent imperatives revealed by this action-research stands one unequivocal truth: the developing brain of a child or adolescent must be afforded the highest possible level of protection. Overmedication in early life, particularly when imposed without understanding, capacity, or informed consent, constitutes a direct assault on the foundations of personhood and cognitive sovereignty. It is not only physiologically harmful, as the evidence now confirms, but legally and ethically indefensible. Current practices normalize the chemical restraint of minors under institutional rationales of risk, disorder, or behavioral management, effectively bypassing their rights to participate in decisions about their own minds, bodies, and futures. This dissertation demonstrates that shared decision-making and capacity recognition are not luxuries reserved for adulthood, they are legal and moral obligations that must begin in childhood, adapted developmentally and contextually. Children must be listened to not merely as future adults, but as rights-holding individuals with perspectives shaped by pain, context, and intelligence.

The EU BEACON One Health Education and Technology COST action, established and led by the author during the course of this doctoral action research, emerges as the strategic platform through which these reforms are not only proposed but operationalized. At its core, EU BEACON affirms that education, mental health, and public health are inseparable, and that no child's neurodevelopment or emotional growth should be endangered by ignorance, diagnostic overreach, or institutional neglect. The initiative's focus on integrated, ethically grounded education, beginning with dignity, trust, and participatory capacity-building, marks a paradigm shift: from paternalism to partnership, from control to care, from submission to shared responsibility.

The next steps are already underway. What remains is to scale, to protect, and to ensure that never again is a request for help punished or willfully ignored.

Chapter 5: Conclusion

This dissertation beared witness to a reality as devastating as it is rigorously substantiated: the Spanish mental health system, in its current configuration, systematically violates constitutional guarantees afforded to those labeled with psychiatric diagnoses, precisely at the moments they are most in need of protection. What is framed legally as an exceptional response to crisis has, in practice, become a permanent condition of structural coercion, epistemic silencing, and institutional impunity. This is not a theoretical argument. It is grounded in lived experience, corroborated by extensive documentation, expert testimonies, and the institutional record itself. The evidence is unequivocal: in Spain today, seeking help in moments of emotional distress or existential vulnerability often results in the total erosion of basic rights, liberty, dignity, family integrity, and the capacity to speak credibly or access support. The very act of narrating one's suffering becomes dangerous in a context where narrative itself is colonized by institutional power. In a society marked by postmodern relativism and professionalized doubt, abusers can easily weaponize narrative therapy, reframe events to suit institutional interests, and conceal violence behind a façade of clinical discourse, especially when they control the diagnostic framing, the material conditions, and the channels of recognition. The law does not formally authorize such outcomes. But they occur routinely, because the system lacks meaningful judicial oversight, and operates on a structural presumption of incapacity that nullifies autonomy without due process, remedy, or accountability.

This is not protection. It is harm. A regime in which those suffering are drugged, silenced, beaten, and abandoned, while the perpetrators remain protected, by protocol, by habit, by the very safeguards that should prevent abuse. Asking for help becomes dangerous. Reporting is exhausting and retraumatizing. The person, already hurt, is blamed, discredited, and made invisible. My case is not isolated. It is exemplary of a system that punishes vulnerability, rewards indifference, and shields cruelty with medical authority. The burden is placed entirely on the victim, to prove, to survive, to explain, while the system absolves itself of responsibility and consequence.

This must end. No diagnosis justifies forced drugging. No moment of emotional pain should be converted into lifelong surveillance or legal degradation. The Constitution, if it still binds this system, does not permit irreversible decisions made without consent or recourse. What happened, and is still happening, must be acknowledged as a failure of law, of medicine, and of the basic human compact. This thesis calls for urgent structural repair, not theoretical debate. The facts are known. The consequences are brutal. The time to act is now, as lives are ruined and lost, mounting, piling, pilling still, as if not knowing better, evidence also growing stronger, to ensure it all stops.

Final note on my own case, and all that resemble:

Defamation, as a legal and moral transgression, constitutes not merely a harm to reputation, but an assault on the very foundation of civil and democratic life: the ability of individuals to be heard and believed in public. When falsehoods are knowingly propagated with the intent to damage another's standing, to obstruct their access to justice, or to incite coercive action, defamation becomes a weapon of structural violence. In many legal systems, it is rightly criminalized because it distorts truth, injures dignity, and undermines the rule of law. However, when defamation is used not solely to discredit, but as an instrument to trigger psychiatric intervention, especially forced drugging, it escalates into an act of medical abuse and potentially a form of torture under international human rights law. The gravity of such compounded violence cannot be overstated. False narratives that portray an individual as irrational, dangerous, or incapable, when strategically constructed to justify psychiatric diagnosis and subsequent involuntary medication, represent a convergence of epistemic injustice, legal corruption, and biomedical domination. They exploit the asymmetry of trust afforded to medical authority and the presumption of objectivity in clinical decision-making. The individual is not only disbelieved, but actively stripped of credibility, legal agency, and bodily sovereignty.

Forced drugging, when based on fabricated allegations, amounts to a direct violation of the principles of informed consent, proportionality, and the right to refuse treatment. It entails the chemical modification of the brain and body without medical necessity, against the will of the subject, and based on a manipulated or deceitful account of reality. The consequences, neurological impairment, emotional suppression, cognitive dulling, metabolic damage, and enduring social exclusion, are irreversible for many. The attack is no longer only reputational, but physiological and existential. In such cases, the defamation operates not only as a predicate crime but as a vector of structural destruction, facilitated by institutions that fail to verify claims, uphold procedural fairness, or apply clinical scrutiny. This compounded violence, defamation plus forced psychiatry, should be understood as an aggravated violation of fundamental rights. It converts slander into state-sponsored degradation, enlists medicine as an instrument of silencing, and annihilates the possibility of recovery, recognition, or reparation. These interventions, administered without consent and based on fabricated accounts, result in measurable physical, cognitive, and emotional harm, including loss of health, professional standing, and legal agency, when not life itself.

It sets the victim as if cared for by abusers, completely at their mercy, facing further threats and the annihilation of all a human cherishes in life. Social death ensues, isolation, a sort of lynching.

Torture.

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