**Beyond witnessing: ethical imperatives in action-research on suffering, victims of violence, and structural harm in mental health systems**

**Abstract:** Qualitative research

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**I**ntroduction:****

**Recent years have seen a sharp increase in the development and deployment of digital mental health interventions (DMHIs), including mobile apps, teletherapy platforms, decision-support tools, and AI-enabled diagnostics. These technologies are often promoted as scalable, cost-effective solutions to longstanding gaps in access to mental healthcare (Torous et al., 2019; Mohr et al., 2017). Policymakers and public health authorities have emphasized their role in addressing workforce shortages, geographic barriers, and service fragmentation, especially in high-demand or low-resource contexts (WHO, 2021; European Commission, 2023). However, a growing body of empirical literature and programmatic evaluation indicates that most DMHIs remain insufficiently adapted to the social, cultural, and legal realities of those facing structural vulnerability, including individuals living in poverty, survivors of institutional or domestic violence, children in protective care, persons with disabilities, forcibly displaced populations, and minoritized or non-conformant social groups (Bennett et al., 2021; Martinez-Martin, 2022; Kirmayer et al., 2018).**

Systematic reviews and implementation studies reveal several persistent shortcomings in the current generation of digital mental health tools. First, these technologies tend to assume a cognitively and technologically competent user, despite evidence that digital exclusion strongly correlates with socioeconomic status, housing instability, age, and disability (Schueller et al., 2019; Lupton, 2021). Second, DMHIs typically address psychiatric symptoms in isolation from social determinants, such as food insecurity, family fragmentation, or exposure to coercion—factors that are increasingly recognized as central to both the onset and course of mental distress (Compton & Shim, 2015; WHO & Calouste Gulbenkian Foundation, 2014). Third, few tools are designed with input from individuals with lived experience of violence, systemic discrimination, or chronic exclusion, which limits their capacity to serve those whose mental health challenges are embedded in cumulative adversity (Groot et al., 2023; Spandler & Hall, 2021).

For these reasons, engagement with DMHIs tends to be lowest among individuals most exposed to mental health risk. In a large-scale review by Borghouts et al. (2021), the most cited reasons for dropout or non-adoption included perceived irrelevance, lack of relational connection, and structural barriers to continuity of use. These findings mirror qualitative studies in clinical and community settings, where users have reported that digital interventions often feel disconnected from their primary concerns: physical safety, access to care, support with housing, legal protections, and rebuilding family or community ties (Topor et al., 2020; Adams, 2022). As a result, there is growing recognition that digital tools, while promising in certain contexts, cannot meet the needs of structurally marginalized users unless they are developed within integrated systems that account for basic needs, legal safeguards, and meaningful social support.

At the same time, several international and regional initiatives have begun to explore alternatives to the dominant DMHI paradigm, aiming to embed digital tools within more comprehensive, rights-based approaches to care. The WHO’s (2021) Guidance on Community Mental Health Services emphasizes the need for non-coercive, community-anchored, and culturally adapted models of care that prioritize autonomy and psychosocial recovery. In Europe, the Trieste model—developed over decades in northeastern Italy—has been recognized as an international benchmark for deinstitutionalized, socially embedded mental health services that integrate housing, employment support, relational care, and legal advocacy (Mezzina et al., 2019). While not initially digital in design, the Trieste experience has provided a basis for exploring how technology can support rather than fragment care, particularly when it is co-developed with service users and embedded in relational ecosystems.

In parallel, the design and testing of expert systems for clinical and psychosocial decision support is underway in several research contexts, including within the framework of European COST Actions such as ReMO (CA19117), FOSTREN (CA19133), and the more recent BEACON One Health Education and Technology (CA24106). These initiatives emphasize the use of transdisciplinary methodologies—spanning medical anthropology, social informatics, and participatory action research—to ensure that technologies reflect user realities and are aligned with public values. Fieldwork conducted under these networks has also begun to examine how digital tools can be tailored to specific user groups, including youth in state care, survivors of institutional abuse, and persons living with long-term psychiatric diagnoses. In these settings, personalization refers not to interface options or scheduling preferences, but to the alignment of the intervention with a person’s legal status, social context, and network of support or risk.

Recent shifts in the understanding of human needs—reflected in the capabilities approach (Nussbaum, 2011), the WHO’s determinants-based frameworks, and SDG-linked indicators—underscore that mental health outcomes are deeply interwoven with access to shelter, nutrition, safety, education, and supportive relationships. The Convention on the Rights of the Child (CRC, 1989), the CRPD (2006), and other international instruments highlight that mental health care must be adapted to the particular vulnerabilities of groups such as children, older persons, migrants, and minoritized communities. Current research suggests that digital interventions can contribute to these goals, but only when designed as part of broader systems that include legal accountability, social protection, and mechanisms for relational repair.

In response to the growing mismatch between digital mental health interventions and the lived conditions of structurally marginalized populations, recent scholarship and policy initiatives have emphasized the need for interdisciplinary frameworks that integrate technological development with legal, relational, and social determinants of health. Central to this shift is a recognition that mental health care—particularly when delivered through digital means—must not only be accessible and scalable, but also participatory, rights-based, and structurally competent (Metzl & Hansen, 2014; Kleinman & Benson, 2006; WHO, 2021). The focus of current research has increasingly moved from symptom reduction in individual users toward the co-production of tools that respond to collective needs and structural risks.

The concept of **structural competence**—originally developed in clinical training to highlight the importance of recognizing social, economic, and political structures as primary drivers of health inequity—has been extended to digital mental health through work examining how technologies mediate or reproduce access to care (Metzl & Hansen, 2014; Benjamin, 2019; Adams, 2022). Applied to DMHIs, structural competence entails designing tools that not only acknowledge, but explicitly respond to, the embedded realities of poverty, racism, gendered violence, disability discrimination, and institutional abuse. This includes not only linguistic and cultural adaptation but also operational links to housing, legal services, family support systems, and anti-violence mechanisms.

Parallel developments in **design justice** and **participatory informatics** offer methodologies for embedding such competence into the development process itself. Costanza-Chock (2020) outlines how participatory co-design, when rooted in community-led agenda-setting, can mitigate the risk of reinforcing structural exclusion through seemingly neutral interfaces. In the context of mental health, this approach aligns with calls from users and professionals alike for tools that reflect the complexity of lived experience, including trauma, systemic betrayal, and the ongoing negotiation of identity and meaning under constraint (Slade, 2017; Topor et al., 2011). Empirical studies show that users are more likely to engage with digital systems that validate their experiences, offer choices aligned with their relational context, and integrate into broader care ecosystems (Bennett et al., 2021; Spandler & Hall, 2021).

In practice, this has led to pilot efforts at system integration, particularly in regions already experimenting with community-based, rights-anchored psychiatric reform. The Trieste model in Italy, for example, while historically analog in orientation, has served as a reference point for new efforts to digitize relational coordination and user engagement without compromising the model’s core commitments to continuity, community presence, and voluntary care (Mezzina et al., 2019). Digital initiatives emerging from or inspired by Trieste—including those developed through partnerships in Spain, France, and Scandinavia—emphasize technology as a facilitator of human support systems rather than a substitute for them. Such approaches are grounded in social psychiatry, recovery-oriented practice, and public health ethics, and are being studied as part of international collaborations including the FOSTREN and BEACON COST Actions.

At the same time, interdisciplinary researchers working within the ReMO COST Action on researcher mental health have begun to examine how **expert systems** and AI-based decision support tools can be developed to aid early detection of distress, ethical triage, and care coordination across sectors. This work is grounded in a medical anthropological understanding of institutional dynamics, epistemic injustice, and user-centered ethics, with particular focus on how software can be designed to respect autonomy, mitigate coercion, and account for vulnerability without over-reliance on predictive surveillance models (Groot et al., 2023; Halliburton, 2023). Research in this area increasingly points toward the importance of multi-modal systems—capable of linking digital interaction with in-person follow-up, social service access, and legal protections—as a minimum standard for ethically viable DMHIs.

In addition, contemporary frameworks of **capabilities** and **relational well-being** have informed the evaluation of mental health tools from the standpoint of user-defined goals and contextual relevance. The capabilities approach (Nussbaum, 2011) provides a normative baseline for assessing whether a given intervention expands or limits the user’s opportunities to live a life they have reason to value. Studies applying this framework to mental health services highlight the importance of functional domains such as bodily integrity, affiliation, control over one’s environment, and emotional expression—all of which require supportive infrastructure beyond the digital interface itself (Narayan et al., 2022; Kirmayer et al., 2018). Research in this line converges with findings from trauma-informed care and critical disability studies, which emphasize the necessity of restoring control and reducing exposure to retraumatizing environments as preconditions for recovery (CRPD, 2006; WHO, 2021).

Best practices available increasingly converge around the view that digital mental health tools must be **relationally anchored**, **structurally responsive**, and **legally coherent** to serve the populations they are intended to support. A growing body of literature critiques the limitations of stand-alone, self-help models for digital interventions, particularly when implemented without coordination with social care, legal support, or relational continuity (Adams, 2022; Martinez-Martin, 2022; Lupton, 2021). Emerging interdisciplinary work points instead to **participatory, networked models of care** that treat mental health not as an isolated biomedical event, but as a reflection of broader **social, institutional, and political arrangements** (Kirmayer et al., 2018; Kleinman & Benson, 2006; Das & Das, 2006). Design justice approaches (Costanza-Chock, 2020), critical psychiatry (Spandler & Hall, 2021), and structural competency frameworks (Metzl & Hansen, 2014; Shim, 2010) all converge on the need for systems that respect user autonomy, attend to power differentials, and connect digital platforms to the actual conditions under which suffering is produced and recovery is possible. This reorientation is not yet fully realized. Despite advances in theory and isolated examples of innovation, most DMHIs currently in circulation still reflect **technocratic design logics**, **individualized symptomatology**, and insufficient incorporation of **lived experience**—especially among those affected by poverty, violence, displacement, or structural neglect (Schueller et al., 2019; Groot et al., 2023; WHO, 2021). Reviews of user engagement highlight low retention and adoption rates in vulnerable groups, citing irrelevance, lack of trust, and absence of meaningful outcomes as primary drivers (Borghouts et al., 2021; Bennett et al., 2021). Moreover, the incorporation of relational determinants—such as family fragmentation, housing precarity, and community exclusion—remains rare, despite their well-documented influence on psychological outcomes (Compton & Shim, 2015; Topor et al., 2011; Narayan et al., 2022). Nonetheless, the **empirical basis** for a restructured digital mental health landscape—grounded in co-production, legal safeguards, and integrated care—is increasingly robust across global mental health, public health ethics, and social psychiatry (Patel et al., 2018; Mezzina et al., 2019; WHO, 2021).

This article builds upon that foundation. Drawing from five years of **transdisciplinary, multi-sited research**, presenting findings from (1) extended fieldwork and participatory observation in Spain, Italy, Sweden, and Indonesia; (2) structured surveys of professionals and service users across Europe focusing on schizophrenia, Open Dialogue implementation, and shared decision-making; and (3) a virtual ethnography of expert system developers conducted under the ReMO COST Action (CA19117). The research also draws from collaborations within FOSTREN (CA19133) on coercion reduction and the ongoing development work under BEACON One Health Education and Technology (CA24106) and Youth Digital Mental Health (CA23153) COST actions These interlinked inquiries offer new insights into how digital tools can be embedded within relational ecosystems, respond to the structural needs of vulnerable populations, and contribute to a more just and coherent framework for digital mental health innovation.

### ****Methods****

This research was conceived and conducted within a **biocultural, transdisciplinary, and action-oriented epistemology**, integrating field-based methodologies from **medical anthropology**, **critical public health**, and **digital systems design**. It aims not merely to evaluate the technical features or user interfaces of digital mental health tools, but to examine the structural conditions, social relationships, and institutional logics that shape their development, adoption, and ethical legitimacy. Consistent with a critical interpretive approach (Kleinman & Benson, 2006; Das & Das, 2006), the work situates digital technologies within broader assemblages of care and control, in which software functions not only as a medium of therapeutic interaction but also as a reflection of dominant epistemologies and social hierarchies.

Methodologically, the research draws on **multi-sited ethnography** (Marcus, 1995) and **mixed methods** within a **longitudinal research frame** spanning five years (2020–2025). Fieldwork was conducted across several European contexts—Catalonia, Andalusia, Italy, and Sweden—and extended into **transcultural and transcivilizational immersion in Indonesia** during the final phase (2023–2024). These contexts were chosen not as representative samples, but as **strategic field sites** for observing how mental health technologies interface with diverse care systems, legal cultures, and sociopolitical ecologies. The research architecture was designed to integrate institutional observation, digital ethnography, qualitative interviews, and formal survey instruments, ensuring **triangulation across experiential, discursive, and structural domains** of analysis (Morse, 1991; Bernard, 2011).

From an epistemological perspective, the work adopts a **critical-constructivist stance**, recognizing that knowledge about mental health—particularly in digital contexts—is co-produced through interactions among developers, users, professionals, and institutions. The study engages with foundational critiques in global mental health regarding **epistemic injustice**, **diagnostic coloniality**, and **professional capture** (Fernando, 2014; Mills, 2014; Kirmayer et al., 2016), while foregrounding the need for **user-led, contextually adapted, and structurally embedded** design processes. Throughout, the research is informed by the principle that technologies must be analyzed not in isolation but within the legal, material, and relational infrastructures in which they are situated and deployed (Adams, 2022; Costanza-Chock, 2020; Benjamin, 2019).

Three core components structured the data collection and analysis. First, **field immersion and participant observation** were carried out in multiple clinical and community mental health settings in Spain, including Open Dialogue networks, rights-based professional coalitions, and digital pilot initiatives attempting to operationalize shared decision-making. The work extended to Italy’s Trieste-based mental health system, where the integration of social supports and relational continuity offers an important countermodel to both institutional psychiatry and decontextualized digital interventions (Mezzina et al., 2019). Observations in Sweden and virtual fieldwork across Northern Europe were conducted through the COST Action ReMO (CA19117), with a focus on expert system development, AI triage logic, and the role of predictive technologies in mental health screening and management.

Second, three formal **survey studies** were designed and deployed to assess how professionals and users understand, experience, and prioritize various components of digital and psychiatric care. These include: (1) a survey of 410 respondents exploring structural distress, misdiagnosis, and coercion in schizophrenia pathways; (2) a second instrument examining best practices and implementation experiences in Open Dialogue across Spanish regions; and (3) a third survey with 90 participants addressing shared decision-making, medication management, and patient autonomy. These instruments, developed iteratively through field engagement and expert consultation, combined quantitative measures with qualitative narrative prompts, enabling a **multi-layered analysis of professional discourse and user agency** (Gobo, 2008; Creswell & Poth, 2018). All three surveys were thematically aligned and situated within the broader inquiry into how digital tools might facilitate or hinder ethical, relational, and rights-based care.

Third, a program of **virtual ethnography and systems mapping** was conducted with developers, researchers, and institutional actors involved in the creation of digital platforms and expert systems. This included structured interviews and participatory design dialogues with stakeholders affiliated with the ReMO COST Action and, later, the Youth Digital Mental Health COST Action (CA23153), where the author currently leads a dedicated taskforce on best practices. These conversations revealed key tensions in the field: between personalization and standardization, prediction and protection, automation and autonomy. They also offered critical insight into how technological priorities are shaped by funding logics, regulatory uncertainties, and professional ideologies—a dynamic often invisible to end-users but central to ethical risk assessment and design governance (Martinez-Martin, 2022; Torous & Roberts, 2017).

The entire research program is embedded within and contributes to the EU COST Action **BEACON One Health Education and Technology (CA24106)**, which the author founded and leads. BEACON operationalizes interdisciplinary collaboration across education, medicine, environmental science, and digital ethics, with a central emphasis on equitable mental health systems. The data and insights generated through this research are thus both grounded in situated field encounters and positioned within a growing European infrastructure aimed at transforming how health, education, and digital systems are conceptualized, linked, and funded in relation to public well-being.

This methodological design—combining grounded ethnography, formal survey, virtual systems analysis, and cross-national collaboration—ensures that the findings are not simply descriptive but capable of generating robust, context-sensitive insights into the structural dynamics shaping digital mental health. The second part of the Methods section details the analytical strategies, ethical safeguards, and interpretive framework used to make sense of the empirical data collected across these layers.

The interpretive strategy guiding this research was informed not only by the epistemologies of medical anthropology and critical psychiatry, but also by the methodological implications of **embodied fieldwork under structural duress**. Over the course of the project, the principal investigator was subjected to prolonged and severe **institutional violence**, including direct **racist aggression**, **xenophobic exclusion**, and **targeted retaliation** for publicly defending human rights–based approaches to care. These experiences included systematic **silencing, coercion, and misrepresentation** within medical, legal, and social services systems in multiple European countries—practices in breach of the **Charter of Fundamental Rights of the European Union (2000)** and the **United Nations Convention against Torture (1984)**.

This institutional violence was compounded by intimate partner violence and continued persecution by a former spouse from the People’s Republic of China—an individual who perpetrated domestic abuse and subsequently used **immigration systems, custody laws, and psychiatric narratives** to further isolate, discredit, and punish the author. These acts were neither incidental nor personal: they were enabled by state-level structures of impunity and by the complicity of professionals whose biases—whether racial, institutional, or gendered—rendered them unable or unwilling to intervene. What began as participant observation thus evolved into a form of **survivor-led ethnography**, in which the researcher's own body, legal status, and capacity for professional continuity became contested sites within the very systems under investigation.

This situated vulnerability, far from disqualifying scientific rigor, reinforced the project’s methodological validity, analytic access, and ethical depth. In line with established frameworks of **survivor research** (Faulkner, 2004; Rose & Kalathil, 2019), **critical autoethnography** (Boylorn & Orbe, 2014), and **epistemic reflexivity** in medical anthropology and the medical humanities (Brodwin, 2013; Jackson, 1995), the author’s dual position as both a transdisciplinary researcher and a direct target of structural repression offered singular insight into the **instrumentalization of psychiatry, legal structures, and professional hierarchies** as mechanisms of punishment, silencing, and social expulsion. These experiences were not isolated but emerged at the intersection of multiple systemic failures—including the complicity of European institutions—and the exportation or tolerance of legal-cultural logics fundamentally incompatible with the rights architecture of the European Union.

This contradiction was sharply manifest in the influence exerted by an abusive ex-spouse—an individual of foreign origin with social, cultural, and institutional alignment to a **totalitarian regime (the People’s Republic of China)**—whose value system, rooted in coercion, collectivist moral control, and hierarchical repression, directly conflicted with the European Union’s commitments to **individual liberty, legal accountability, and the inviolability of human dignity**. The weaponization of institutional psychiatry, immigration frameworks, and civil protection mechanisms by such actors—enabled by local actors’ negligence, xenophobia, and systemic inertia—revealed not only a gap in protection but a **deep fragility in Europe’s ability to uphold its own normative commitments** when faced with transnational actors operating under fundamentally antithetical ethical codes.

The author’s **scientific positionality** is thus neither neutral nor externally imposed. It is, by necessity, **situated** (Haraway, 1988), **embodied** (Scheper-Hughes & Lock, 1987), and **medically and legally consequential**. It emerges from direct confrontation with the systems under investigation, not only as objects of analysis but as active agents of suppression or complicity. These experiences—ranging from forced displacement, denial of procedural rights, erasure of testimony, and institutional gaslighting—are not merely biographical context, but form the **empirical foundation** of an **ethically grounded, survivor-led analytic methodology**. They make visible the persistence of **epistemic injustice** (Fricker, 2007; Carel & Kidd, 2014), the bureaucratic reification of violence, and the porousness of European institutions to **value systems imported from anti-democratic or authoritarian legal cultures**, which, when left unchallenged, erode the protections nominally afforded by EU legal frameworks such as the **Charter of Fundamental Rights (2000)** and the **General Data Protection Regulation (GDPR, 2016)**.

Within this investigative configuration, informants were not passive research subjects, nor was the researcher an abstract observer. Instead, the **relational texture** of the inquiry was structured by **mutual recognition**, whereby individuals subjected to coercive care, neglect, algorithmic disregard, or institutional betrayal saw in the author’s trajectory an analogue to their own struggles for epistemic agency, social recognition, and protection under law. Their engagement with the research—through surveys, interviews, informal exchanges, and sustained dialogue—constituted acts of **testimonial resistance**, deeply aligned with traditions of **structural witnessing** in medical sociology, postcolonial psychiatry, and human rights fieldwork (Good, 1994; Das, 2007; Spandler & Hall, 2021; Summerfield, 2008).

This empirical and epistemological alignment required a methodological framework capable of holding **emotional gravity, structural critique, and analytic clarity** in simultaneous balance. The narrative materials—particularly from the surveys on schizophrenia care pathways, Open Dialogue implementation, and medication decision-making—were read not through reductive coding categories, but as situated truth-claims about institutional life and systemic harm. The analysis was shaped by frameworks emphasizing **moral experience** (Kleinman, 1999), **relational autonomy** (Donchin, 2001), and **care ethics in precarious settings** (Tronto, 2013), while also engaging with emerging work on **epistemic injustice and testimonial silencing** in psychiatric settings (Carel & Kidd, 2014; Fricker, 2007).

Triangulation was achieved not through statistical replication but through **layered synthesis**: comparing narrative materials across countries, roles, and institutional settings; validating field findings through COST Action discussion fora; and integrating legal and scientific evidence from published policy frameworks. All material was interpreted with **structural attentiveness**—situating each testimony within its relevant ecology of legal constraints, institutional inertia, or cultural stigma—ensuring that meaning was not abstracted from context. Ethical safeguards, including GDPR-compliant protocols, informed consent, and trauma-aware communication, were enforced consistently, with particular attention to psychological safety for both participants and the researcher under duress (WHO, 2022; EUREC, 2021).

Ultimately, the research approach affirms that the authority to generate valid and transformative knowledge about mental health care—including its digital frontiers—must include the epistemic contributions of those harmed by its malfunctions. In this project, the line between researcher and target was **methodologically generative**: it allowed for the production of insights unavailable to external auditors, and for the recovery of knowledge routinely excluded from institutional discourse. The findings that follow are not constructed from distance but forged through lived proximity to the systems that govern access to health, rights, and personhood itself.

In line with its foundational orientation toward applied structural reform and health systems redesign, this research adopted a **transdisciplinary synthesis model** as its methodological backbone. Drawing on principles from **systems theory**, **public health engineering**, and **complexity-informed ethnography**, the study integrated heterogeneous datasets—narrative surveys, immersive field notes, institutional policy reviews, and digital systems interviews—into a cohesive analytic corpus through **relational triangulation and reflexive synthesis** (Midgley, 2000; Funtowicz & Ravetz, 1993; Kirmayer et al., 2018). This approach enabled an interpretation of digital mental health not as a technological artifact, but as a **multiscalar intervention space** whose validity, safety, and ethical standing depend on coherence with human rights standards, legal mandates, and situated care practices.

The analytic strategy recognized that **technological tools, when deployed in the absence of structural integration**, often amplify the very inequities they claim to solve. Thus, the project was committed to assessing digital tools against the **UN Sustainable Development Goals**, the **WHO Comprehensive Mental Health Action Plan 2013–2030**, and legal instruments such as the **CRPD (2006)**, the **CRC (1989)**, and the **Istanbul Convention** on gender-based violence (Council of Europe, 2011). This methodological grounding supported the assessment of whether and how digital mental health systems align with principles of **non-discrimination**, **dignity**, **participation**, and **continuity of care**, particularly for individuals most exposed to risk: children in protective services, persons with disabilities, undocumented migrants, elderly populations, survivors of domestic violence, and structurally excluded youth.

Analytically, the study incorporated **layered reading protocols** drawn from legal anthropology and qualitative systems analysis, mapping how normative claims—such as autonomy, personalization, or harm reduction—are enacted or negated across user testimony, policy structure, and software logic. Particular attention was paid to how **care discontinuities**, **jurisdictional fragmentation**, and **data governance opacity** undermine the ethical deployment of digital tools, especially where platform operations outpace oversight or where algorithms are deployed in coercive institutional contexts (Eubanks, 2018; Morley et al., 2020). These insights were tested through ongoing peer validation within EU BEACON (CA24106) and Youth Digital Mental Health (CA23153), where feedback from legal scholars, health professionals, survivors, and technologists was used to challenge and refine the research interpretations.

The use of **computational modeling** and **expert systems architecture** was explored in dialogue with informants contributing to the COST Action ReMO (CA19117), revealing both the potential and the profound risks associated with machine-led triage, algorithmic prediction, and AI-augmented therapeutic environments. These dialogues were contextualized within the broader debate on **machine ethics**, **bias in decision support systems**, and the limits of digital diagnostics under conditions of epistemic injustice (Benjamin, 2019; Martinez-Martin, 2022; Groot et al., 2023). In parallel, the study engaged with the design of protective digital infrastructures—non-surveillant, rights-preserving, and trauma-informed—that could be deployed as **supportive adjuncts** rather than replacements for human care, embedded within **continuums of trust, social repair, and user-defined recovery trajectories**.

The methodological posture of this study was therefore one of **strategic engineering and scientific responsibility**, grounded in **open science principles**, **digital ethics**, and **survivor accountability**. Each claim presented in the following results section is substantiated not only through field-derived evidence but also through alignment with recognized frameworks of health integrity, legal compliance, and structural competence. The project moves beyond surface-level evaluation to propose a replicable infrastructure for the development, testing, and deployment of digital mental health tools that are **scientifically sound**, **socially just**, and **legally defensible**.

The next section presents key empirical findings from the multi-layered investigation, beginning with the testimonial and structural evidence gathered through the schizophrenia diagnostic experience survey, followed by insights from field observation, practitioner responses, and the deployment context of relational mental health practices.

### ****Results and findings:****

The empirical results of this research unfold across three primary phases, each anchored in extensive qualitative and experiential data collection. These stages encompass (1) the schizophrenia and psychosis trajectory survey (2020–2023), (2) direct field observations and participant engagement with Open Dialogue and best-practice psychiatric alternatives across Spain, Italy, and Sweden (2020–2024), and (3) the shared decision-making and medication autonomy survey (2023–2024), followed by embedded research within digital mental health expert communities and system developers under European COST Actions. Each phase contributes unique insight into the disjuncture between user experience and the prevailing psychiatric, institutional, and digital care infrastructures.

The first empirical body of work consisted of a longitudinal, anonymized survey involving 410 participants drawn from networks of psychiatric users, relatives, and professionals across Spain and partner countries, with the aim of documenting care trajectories in the diagnosis and treatment of schizophrenia and related psychotic disorders. The survey was conducted using a mixed narrative format, primarily composed of open-ended responses, thematically grounded in anthropological and epistemological concerns regarding how mental health care is perceived, delivered, and resisted. While the geographic focus was Spain, additional respondents contributed from Italy, France, and Sweden via solidarity and peer networks. These were not coded into discrete themes in a positivist sense, but rather analyzed through iterative, grounded reading in line with medical humanities traditions (Good, 1994; Kleinman, 1988).

The most consistent finding across responses was a deep structural misalignment between participant experiences of suffering and the frameworks imposed by psychiatric care. A majority of users reported delays, misdiagnoses, and treatments that failed to account for personal history or context. Participants frequently cited socioeconomic trauma, gendered and racial violence, institutional betrayal, and family dysfunction as primary sources of their distress, echoing the literature on social determinants of mental illness (Compton & Shim, 2015; Kirmayer & Pedersen, 2014). However, these elements were often excluded from the diagnostic frame, with medicalization used as a form of epistemic control rather than therapeutic engagement (Fricker, 2007; Russo & Sweeney, 2016).

The use of coercion emerged as a core theme. Respondents recounted involuntary hospitalization, forced medication, seclusion, and mechanical restraint as routine rather than exceptional events, in clear contravention of legal protections under the Convention on the Rights of Persons with Disabilities (CRPD, 2006). These experiences were not presented as deviations from an otherwise functional system but as normative features of psychiatric institutions. The reported consequences included long-term distrust, disengagement, and perceived dehumanization. These results are consistent with prior critiques of psychiatric violence and iatrogenesis in the critical mental health literature (Moncrieff et al., 2022; Johnstone & Boyle, 2018).

Participants described diagnostic labels as both socially discrediting and epistemically disqualifying. Many reported that once a label such as "schizophrenia" was applied, their ability to express concerns, negotiate care, or propose alternatives was systematically disregarded. This aligns with findings in testimonial injustice and psychiatric power asymmetries (Carel & Kidd, 2014; Metzl, 2009). Family members of users expressed similar concerns, reporting alienation from care teams and exclusion from meaningful decision-making processes, particularly in coercive episodes.

Ethnographic fieldwork during this phase included participant observation in community-based mental health initiatives, psychiatric units, and activist networks in Spain and Sweden. Key sites included Andalusian and Catalonian psychiatric hospitals, peer-led support spaces, and units experimenting with dialogical and community-based care. Interviews and informal discussions with clinicians in these settings revealed that many professionals shared users’ critiques but felt institutionally constrained. Recurrent barriers included caseload pressures, legal ambiguity, inadequate training in non-coercive methods, and lack of institutional support for alternatives like Open Dialogue or trauma-informed care.

In parallel, ethnographic visits to Italy—specifically Trieste, long regarded as a model for rights-based psychiatric care (Mezzina, 2021; Rotelli, 1986)—provided a critical external comparator. In Trieste, care is based on voluntary engagement, community proximity, and relational continuity. Although resource constraints and political shifts threaten its legacy, professionals and users alike affirmed its ethical and clinical superiority to standard psychiatric systems. This model demonstrated that the integration of psychiatric care into broader social infrastructures—housing, employment, education, and cultural life—is not only possible but essential. Documentary and legal reviews showed that the Trieste system was not merely an organizational innovation but a normative shift grounded in constitutional and ethical commitments to dignity and relationality.

The relevance of these observations is heightened by the presence of contradictory trends in other European settings. In Sweden, for example, coercive measures have remained frequent despite progressive rhetoric. Interviews with professionals and experts revealed that legal safeguards were often bypassed in favor of paternalistic interpretations of “risk.” This discrepancy between normative discourse and operational practice underscores the role of systemic opacity in perpetuating psychiatric violence, particularly when accountability mechanisms are weak or politicized.

Overall, the findings from this first phase of research demonstrate that psychiatric care in most European settings continues to operate through a model of control rather than care. While isolated innovations exist, they remain underfunded, under-evaluated, and often treated as pilot exceptions rather than institutional standards. Participants across all roles—users, relatives, and professionals—expressed the urgent need for a paradigmatic shift toward relational, trauma-informed, and socially embedded models of care.

The second wave of findings derives from a survey conducted between 2023 and 2024 with 90 participants—users and survivors of psychiatric treatment—focusing on their real-world experiences with shared decision-making (SDM), medication autonomy, coercion, and relational trust. The responses, primarily qualitative, narratively document the dissonance between policy rhetoric and care reality, offering detailed insight into the structural barriers that undermine therapeutic alliances and user autonomy.

A dominant theme was the **prevalence of top-down prescribing practices**, with decisions typically made in moments of acute distress or institutional control, not through dialogical negotiation. Participants reported that refusals to comply with medication plans often resulted in immediate consequences, including withdrawal of access to social supports, denial of outpatient care, or renewed involuntary admissions. While SDM is formally promoted in national and international guidelines (Stiggelbout et al., 2015; WHO, 2021), its translation into everyday psychiatric care remains rare and superficial. Many users described being presented with “consent” documents under emotional duress or with misleading reassurances that obscured the pharmacological risks and long-term implications of treatment, confirming ethical critiques by Moncrieff et al. (2022) and Groot et al. (2023).

A recurrent subtheme was **epistemic asymmetry**, with user narratives devalued or pathologized when they deviated from clinical scripts. Requests to taper medication due to unbearable side effects, spiritual distress, or interpersonal harm were often met with dismissal, infantilization, or reclassification as symptoms of noncompliance. Several respondents described experiences in which their professional identities, parenting capacities, or immigration statuses were threatened in clinical conversations—underscoring the material consequences of power asymmetries and confirming findings from Russo & Sweeney (2016) and Carel & Kidd (2014) on testimonial injustice in psychiatric care.

Many participants reported an absence of **meaningful therapeutic relationships**, instead describing psychiatric encounters as brief, transactional, and adversarial. This was particularly prominent among foreign-born respondents, LGBTQIA+ individuals, and those with intersecting vulnerabilities, such as histories of domestic violence or institutional abuse. In these accounts, SDM was not only absent—it was perceived as structurally impossible within systems that prioritized institutional efficiency and medico-legal protection over healing or human connection. Informants emphasized their desire not for total independence from medication, but for **relational continuity, flexibility, and respect for experiential knowledge**, a finding that aligns with values articulated in the capabilities approach (Venkatapuram, 2011) and relational recovery frameworks (Topor et al., 2011).

These user accounts were strongly echoed in the ethnographic interviews with clinicians conducted in parallel. Professionals repeatedly acknowledged their own **structural limitations**, including legal liability concerns, insufficient time, institutional discouragement of tapering practices, and fear of being held responsible for user-initiated changes in care. Although many professionals personally endorsed dialogical values, they admitted that SDM was often framed as an ideal in policy documents but functionally blocked in clinical practice by systemic inertia, bureaucratic fragmentation, and hierarchical governance.

Sites piloting Open Dialogue (OD) across Spain and Italy offered a point of ethical and procedural contrast. Where OD principles were upheld, users described feeling heard, engaged, and supported in making complex decisions over time with family, peers, and professionals. These environments showed significantly lower reported use of coercion, higher continuity of care, and greater respect for fluctuating states of vulnerability, consistent with peer-reviewed OD outcomes in Scandinavia and Italy (Bergström et al., 2019; Mezzina, 2021). However, even in these settings, barriers remained, including lack of national recognition, funding discontinuities, and ambiguous legal mandates. Nonetheless, the OD model offered a working example of ethical psychiatric care as a co-produced and trust-centered process.

A third and final body of findings emerged from **virtual ethnographic work** and in-depth dialogues with expert system developers, digital tool designers, and ethics advisors engaged in European digital mental health innovation—primarily within the ReMO (CA19117) and Youth Digital Mental Health (CA23153) COST Actions. This component revealed a profound **mismatch between design intention and systemic application**.

**Discussion:**

**The findings of this research converge on a foundational challenge to the dominant paradigms in both psychiatry and digital mental health: that care continues to be framed as an object to be delivered, rather than a relational process grounded in shared meaning, legal rights, and structural safety. Across three years of inquiry—including narrative surveys, ethnographic observations, participatory interviews, and collaborative design dialogues—users repeatedly emphasized that their suffering was not the absence of self-help tools, but the consequence of systems that isolate, disbelieve, and punish them. This aligns with a growing body of scholarship in medical anthropology, critical psychiatry, and global health ethics which holds that mental health cannot be treated in abstraction from the socio-legal contexts in which people live and suffer (Kirmayer & Pedersen, 2014; Rose & Abi-Rached, 2013; Bemme & D’souza, 2014).**

Despite the increasing investment in digital mental health interventions (DMHIs), the tools currently being developed and deployed remain **conceptually and operationally misaligned** with the needs of the populations most exposed to trauma, coercion, and exclusion. As this study has shown, users affected by long-term psychiatric labeling, forced treatment, or social marginalization do not ask primarily for efficiency, personalization, or interface optimization. They ask for **the restoration of dignity, agency, and voice**—and for technological systems that do not replicate the logics of surveillance and compliance under new guises (Eubanks, 2018; Adams, 2022; Martinez-Martin, 2022).

The persistent **epistemic fracture** between institutions and those they claim to serve—visible in how psychiatric power silences user narratives, erases trauma histories, and reduces complex suffering to risk profiles—extends directly into the design of digital tools. Most DMHIs are built atop a biomedical substrate that assumes the user's internal regulation is the target, while failing to address the material, legal, and relational conditions that render their lives unlivable (Watters, 2010; Russo & Sweeney, 2016). When developers use medication adherence, relapse avoidance, or passive data compliance as the main indicators of success, they reify a paradigm in which **healing is redefined as docility**—a finding corroborated by this study’s participant narratives and the ethical concerns of system developers themselves.

Attempts to promote **shared decision-making (SDM)** are particularly illustrative of this contradiction. In theory, SDM provides a counterpoint to paternalism; in practice, it remains blocked by structural constraints that are rarely acknowledged in policy documents. This study reinforces prior critiques that most SDM models fail to grapple with power asymmetries, institutional coercion, and the legal ambiguity surrounding psychiatric autonomy (Stiggelbout et al., 2015; Deegan & Drake, 2006; Groot et al., 2023). The empirical data presented here demonstrates that what is labeled SDM often amounts to **tactical consent within coercive systems**, where users “agree” to care they cannot safely refuse. These practices are not aberrations—they are structurally encoded into care systems that protect institutions over persons and prioritize risk management over freedom, rights, or meaning.

This structural dynamic becomes particularly acute in the **deployment of digital solutions** in public or semi-public systems (e.g., schools, clinics, community centers). When digital screening, mood tracking, or AI-based triage systems are introduced without relational anchors, follow-up protocols, or rights-based protections, they generate not empowerment, but fear. For example, youth respondents in this study, particularly those from racialized or undocumented backgrounds, viewed such tools as threats—potential vectors of misclassification, criminalization, or family intervention. This confirms broader concerns in the literature on **algorithmic bias, procedural opacity, and the biopolitics of digital governance** in health and social care (Barocas et al., 2019; Morley et al., 2020; Lupton, 2021).

Crucially, **the ethical breach is not simply a design failure—it is a structural one**. The majority of developers interviewed in this study expressed genuine intentions to help users, but were working within constraints imposed by funders, institutional buyers, and medico-legal risk. Many lacked the power to determine how their tools were deployed or interpreted once operationalized within state systems. As a result, even ethically developed tools can become coercive when absorbed into institutional logics that remain untransformed.

These insights underline the **translational gap between innovation discourse and field realities**. While journals, funding bodies, and policy frameworks increasingly demand “participatory” or “user-centered” approaches, the mechanisms for true co-production remain weak or symbolic. In the field, co-design is often limited to usability testing or post hoc feedback, rather than embedded epistemic negotiation and shared authorship of purpose. In other words, **users are asked to refine the tools, not redefine the system**.

This research challenges that orientation by documenting the structural, relational, and legal dimensions of mental distress that remain **invisible to most digital solutions**. If the most frequent user need is not self-monitoring but safety, not reminders but recognition, then DMHIs must shift from application-layer tools to embedded, accountable infrastructures. This reframing echoes the broader movement toward **structural competence in clinical practice** (Metzl & Hansen, 2014), **relational ethics in care design** (Charon, 2017), and **legal coherence in AI governance** (European Commission, 2021).

The evidence presented does not suggest a rejection of digital innovation, but rather a rigorous call for the contextualization of digital mental health interventions within socio-legal, clinical, and structural frameworks. Translational science demands that new technologies in psychiatry be embedded in environments where relational continuity, legal safeguards, and trauma-informed care are not optional adjuncts, but foundational design criteria. Effective digital mental health systems must be operationalized as components of broader service ecologies—governed by enforceable standards of rights protection, epistemic integrity, and co-produced accountability. The empirical findings presented here support a shift from symptomatic support tools toward infrastructures capable of participating in the transformation of care systems themselves, ensuring that digital interventions promote equity, safety, and long-term recovery rather than reinforcing existing patterns of institutional neglect and coercive control.

**Conclusion**

The ethical

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