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Psychiatry stripped naked: Current human rights violations in psychiatry in Germany, Greece and the rest of the world

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ABSTRACT: Psychiatric human rights violations are commonplace: denial of milder means that would serve the same purpose; bodily harm through the administration of psychotropic drugs and electroshocks using formal physical or informal force. Competent support in their reduction and discontinuation and non-psychopharmacological and human rights oriented assistance for people, such as those provided by the Παρατηρητήριο για τα Δικαιώματα στο χώρο της ψυχικής Υγείας (Observatory for Human Rights in Mental Health in Thessaloniki), are in short supply.

KEY WORDS: Withdrawal, iatrogenesis, informed consent

The Universal Declaration of Human Rights, adopted by the United Nations General Assembly in 1948, guarantees the indivisible legal rights of all individuals. This became a legally binding international covenant in 1976, known as the Civil Covenant. The

Civil Covenant protects basic human rights such as the right to life, protection against torture, slavery and arbitrary state action, and the right to freedom of thought, religion, belief, expression, assembly, and association. These same rights are included in various conventions of particular regions in the world., e.g., the "Convention for the Protection of Human Rights and Fundamental Freedoms" ("European Convention on Human Rights" – ECHR), which was adopted by the Council of Europe in 1950 and entered into force in 1953. The constitutions of the nation states also enshrine these rights.

Worldwide, people with psychiatric diagnoses face a disregard for their human rights. The UN General Assembly passed the Convention on the Rights of Persons with Disabilities on December 13, 2006. This ensures that people have the right to make their own decisions about psychiatric treatment. The Convention entered into force in Germany in 2009, in Greece in 2012, in other countries earlier or later, in some countries not yet, e.g., the USA. Government agencies that ratified the convention must implement it as applicable law.

The standards of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) guarantee people with disabilities, which includes people with psychiatric diagnoses, an inalienable right to self-determination in making choices about treatment or medical procedures – specifically, Art. 12, 14, 15, 16, 17, and 25d (United Nations 2006). Thus, individuals with psychiatric diagnoses are entitled to the inalienable right to decide the type, frequency, duration, and intensity of assistance to the extent it can be offered to them. The first general principle of the UN CRPD emphasizes:

> *"the respect for the inherent dignity of human beings, their individual autonomy, including the freedom to make their own decisions, and their independence"* (Beauftragter der Bundesregierung, 2018, p. 9).

All forms of substituted decision-making are no longer permitted. Instead, states must provide supported decision-making under Article 12(3) (United Nations 2014). In recent years, various UN bodies have clearly and unequivocally advocated for a ban on all coercive measures in psychiatry considering the UN Convention (Zinkler & von Peter 2019). The UN High Commissioner for Human Rights is also one of these bodies. Article 12 (Equal Recognition Before the Law) of the UN CRPD stands in stark contrast to the realities of the psychiatric field. In Article 12, the states that ratified the UN CRPD committed themselves:

1. States parties affirm that persons with disabilities have the right to be recognized everywhere as subjects of rights.
2. States parties recognize that persons with disabilities enjoy legal capacity and agency in all areas of life equally with others.
3. States parties must provide disabled people with the necessary assistance to

exercise their legal capacity.

4. States parties shall ensure that they provide suitable and efficient measures to prevent abuses on all measures related to the exercise of legal capacity in accordance with international human rights law. (Beauftragter der Bundesregierung 2018, p. 14).

Despite ratification and thus the entry into force of the law, people with psychiatric diagnoses continue to receive neuroleptics and other psychotropic drugs as well as electroshocks without free and informed consent or as part of coercive measures. National psychiatric laws and care law procedures continue to allow this (United Nations 2017). People who should be protected by the UN CRPD are still being systematically subjected to formal and informal coercion.

It is not only the UN CRPD that is extremely critical of psychiatric treatment using formal or informal coercion. Various United Nations bodies speak of ill-treatment and even torture in this context. For example, Juan Méndez, the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, as well as the United Nations treaty bodies, have found that involuntary treatment and other psychiatric interventions taking place in healthcare facilities can constitute forms of torture and ill-treatment (United Nations 2013).

Seid al-Hussein, the United Nations High Commissioner for Human Rights, mentions different human rights violations in case of administration of psychiatric measures without informed consent or carried out under false presences:

> *"Involuntary treatment refers to the administration of medical or therapeutic procedures without the consent of the individual. Treatment administered, for example, on the basis of misrepresentation would constitute involuntary treatment, as would treatment given under threat, without full information or on dubious medical grounds. Guaranteeing informed consent is a fundamental feature of respecting an individual's autonomy, self-determination and human dignity. (…) Forced treatment and other harmful practices, such as solitary confinement, forced sterilization, the use of restraints, forced medication and overmedication (including medication administered under false pretences and without disclosure of risks) not only violate the right to free and informed consent, but constitute ill-treatment and may amount to torture"* (United Nations 2017, pp. 7 & 11 – Emphasis P.L.).

In Germany, you can see the practice of formal and informal coercion in the announcement of the German Medical Association. This organized medical profession not only wants to adhere to the principle of joint decision-making by doctor and patient ("shared decision-making"), i.e. ignoring the indivisibility of the fundamental right to physical and mental integrity based on the inalienable right to self-determination. It ignores the norms of

the UN CRPD as a whole, as if they had never entered into force. The psychiatric special laws reject the legal provision that requires the court to appoint a guardian for consenting to compulsory treatment in case of incapacity to consent, even though it is fundamentally debatable in terms of human rights. The German Medical Association states this.. According to this:

> *"... the consent of a patient's representative is generally not required for compulsory treatment of the incipient condition"* (Bundesärztekammer 2023, p. 4).

The situation in Greece is basically the same as in Germany, as seen from the rebuke of the Committee on the Rights of Persons with Disabilities of the UN CRPD:

> *"The Committee is concerned about discriminatory legal provisions, including in Law No. 2071/1992, and the corresponding practice of involuntary hospitalization and deprivation of liberty of persons with psychosocial or intellectual disabilities, as highlighted in the Greek Ombudsman's report of July 2019, and about the use of coercive methods, such as mechanical restraints on persons with psychosocial or intellectual disabilities.*
>
> *In line with its guidelines on the right to liberty and security of persons with disabilities (A/72/55, annex I), the Committee urges the State party to repeal all laws allowing for the involuntary deprivation of liberty on the basis of impairment, end the use of forced treatment, restraints and coercive methods, and provide effective remedies for persons with disabilities deprived of their liberty on the basis of impairment"* (United Nations 2019).

Individuals or associations can learn how to file complaints about violations of the UN CRPD by visiting the United Nations website.[1]

Formal coercion

People with psychiatric diagnoses are subjected to formal coercion through the infringement of their human right to physical integrity:

- by the forced administration of psychotropic drugs and electroshocks – using physical force, following a court order, coercion or threat, for example,
- by threatening a diagnosis with even more significant consequences,
- by threatening prolonged confinement,
- by threat of child withdrawal or withdrawal of parental custody,
- by threat of curfews or restriction of visitation rights,

1 See https://www.ohchr.org/en/reporting_violations

- by threat of restraint and isolation, especially
- by threat of forcible administration of the psychotropic drugs or electroshocks according to the motto *"And if you are not willing, I shall use force."*

Traumatization as a result of psychiatric violence

Traumatization is a frequent consequence of coercive measures. For many psychiatric patients, the forcible administration of psychiatric drugs or electroshocks is a thoroughly traumatizing experience, comparable to the experience of sexual violence. Even psychiatrist associations acknowledge the potentially traumatizing effects of compulsory psychiatric treatment. Traumatology, however, does not include psychiatric violence as a contributing factor to trauma. Different trauma therapies are available, but they do not consider psychiatric violence as a cause of trauma. Thus, patients can't find therapeutic support when dealing with trauma caused by psychiatric violence.

Confinement and isolation

Coercive incarceration invalidates human rights to privacy and family life. Forced treatment impairs the human rights to freedom of thought, freedom of opinion and freedom of expression. Communication with the outside world is restricted, sometimes completely, in others considerably. Complaints related to compulsory hospitalization and treatment are usually not effectively investigated by the judiciary (Schönenberger 1993).

Isolation sometimes for weeks or months is used to force compliance and break people. In Germany, e.g., they locked Gustl Mollath away in a forensic institution for years and isolated him for months. They diagnosed him with a pathological delusion and also accused him of being a danger to third parties. Mollath reported the illegal transfer of millions of euros in illicit funds from the HypoVereinsbank in Nuremberg, which he had discovered through his partner who was employed by the bank. She then accused him of having harmed her, and psychiatrists interpreted his report as a delusion. The Bavarian Minister of Justice, officials, judges, psychiatrists, and the prosecutor's office broke the law and presented false psychiatric opinions. As a result, they deprived him of his freedom, property, and dignity, and he almost lost his life. Only because of massive public reporting did he get free again and finally won €670,000 in compensation for pain: for seven stolen years of life through judicial psychiatric detention from 2006 to 2013, for six months of full isolation, for humiliating shackles on his hands and feet, for public stigmatization as a monster, and further assaults (Schlötterer 2021). For the perpetrators, the deprivation of liberty, the months of isolation, and all the other human rights violations had no consequences.

Restraint

Restraint is a common practice in psychiatry. It is extremely humiliating. Those deprived

of their freedom of movement often remain lying in their own urine or faeces. When individuals who have experienced sexual violence in their childhood or adolescence are forcibly undressed and subjected to body manipulation, it retraumatizes them, especially if they are already in emotional distress. Being restrained is not only life-threatening because of recurrent fires in psychiatric wards. Several psychotropic drugs increase the risk of thrombosis.

Restraint patients may develop a dangerous heart condition called Takotsubo cardiomyopathy. The term was derived from the traditional Japanese squid trap. This has the shape of a pitcher with a short neck (tako-tsubo) and is reminiscent of the left human ventricle at the end of its contraction phase. In the 1990s, doctors identified a condition called "broken heart syndrome" that can cause sudden cardiac death after emotional stress. Veterinarians had known about fang myopathy, while people had been puzzled over the connections for years. This is the term they use to describe the sudden cardiac death of an animal triggered by severe stress, such as being caught. Barbara Natterson-Horowitz, who studied medicine including psychiatry and became a professor of cardiology and medical advisor of the Los Angeles Zoo, co-wrote the book *Zoobiquity: The Astonishing Connection Between Human and Animal Health* together with the journalist Kathryn Bowers. They explain how Takotsubo cardiomyopathy symptoms appear in humans:

> *"In these otherwise perfectly healthy people, a violent emotional shock was enough to change the heart rhythm from calm and steady to treacherous and deadly. Shocked, panicked, frightened, or saddened to death, it floods these patients with stress hormones, such as adrenaline, from their central nervous systems, which are working at full speed. These catecholamines pour into the bloodstream. Like a chemical intervention force, they appear on the scene to provide power and energy to enable escape. But instead of saving the patient, the neuroendocrine rush can rupture plaques, block an artery with a clot, and cause a fatal heart attack. Thus, like fang myopathy, Takotsubo can lead to sudden cardiac death"* (2014, p. 203).

Psychiatric coercion occurs in many forms, formal and informal. The Viennese Association for SACHwalterschaft & PATIENT Advocacy published a "Lexicon of Coercive Measures" with 68 forms of coercion used in the 1990s in Austria's psychiatric hospitals and departments, be it as a threat or as an enforced practice (Info Extra 2000). There are apparently no limits to psychiatric imagination.

Informal coercion

Neuroleptics ("antipsychotics") have a number of toxic, occasionally life-threatening or even fatal adverse effects, whether they are administered compulsorily or with the approval of the affected person. For example, according to manufacturers' summaries of

product characteristics provided to the medical profession, risperidone:[2]

- very often to be associated with parkinsonism (Parkinsonian symptoms comprising immobility of skeletal muscles, muscle stiffness, and muscle tremor), etc.
- often accompanied by depression, agitation, anxiety, increased prolactin concentration in the blood (associated with the risk of tumour formation in the mammary glands, which can degenerate into cancer), flu-like infections, urinary tract infections, pneumonia, dyskinesias (disturbances in the physiological movement of a body region, of a body part or organ), dystonia (pathologically disturbed muscle tension, accompanied by persistent and involuntary contractions of the skeletal muscles and abnormal postures and malpositions of the body or single body parts), falls, etc.
- occasionally with loss of consciousness, epileptic seizures, diabetes, atrial fibrillation (circulating electrical excitation waves in the atria with a frequency of up to 350 beats per minute), pulmonary congestion (symptom of insufficient pumping of the left ventricle, in which blood from the lungs is not sufficiently transported further into the large circulation), tardive dyskinesia (symptom complex of chronic muscle dysfunction), etc. (Lehmann 2017, pp. 76-77).

The disorders, including deaths, are in principle dose-independent and unpredictable.

Damage caused by antidepressants is similar to that caused by neuroleptics. If they are indeed indicated, antidepressants are important and possibly life-saving drugs, writes psychiatrist Giovanni Fava of the State University of New York at Buffalo. But pharmacological interventions can solidify depression, slow its remission, increase the risk of relapse, and make it resistant to treatment, Fava warned. Limit their use to the most severe and most persistent cases of depression and limit the shortest possible time, he strongly recommended, because:

> *"... continued drug treatment may stimulate processes that run counter to the initial acute effects of a drug. Such processes may involve the complex balance of serotonin receptors. Adaptive responses, such as 5HT2A receptor changes or 5HT4 (two serotonin subtypes – P.L.) receptor binding, which are different from the initial ones, may modulate oppositional effects. (...) The clinical events that may follow tapering and/or discontinuation of antidepressant medications are very variable: they may range from no*

2 Marketed as Auroperdal, Donresp, Eperon, Evitrat, Gen-Peridone, Helposper, Nodiril, Perdamel, Perida, Perizal, Phallus, Rescor, Respeecor, Respizim, Ridal, Ridkline, Risina, Risnia, Rispacor, Rispador, Rispefar, Risperdal, Risperidex, Risperidone, Risperlet, Risperon, Rispeva, Rispevon, Rispide, Rispolux, Rispone, Risponz, Rixadone, Rutra, Schizorol, Zoxadon

> *or limited withdrawal symptoms to severe withdrawal syndromes; they may occur within days, if not hours or have a delayed onset; they may fade away or persist for months or years, accompanied by new, disorders and/or greater intensity of the original disturbance. Further, withdrawal and persistent postwithdrawal disorders may be associated with other manifestations of behavioral toxicity, such as loss of clinical efficacy, paradoxical effects, switching to bipolar course, resistance, and refractoriness"* (2021, pp. 37 & 35).

> *"Such processes are not necessarily reversible. The more we switch or potentiate antidepressant drugs the more likely is oppositional tolerance to take place"* (Fava & Offidani 2011, p. 1600).

Tolerance formation is followed by increasing ineffectiveness and treatment resistance, which prompts psychiatrists to augment, i.e., to increase the effect by using further psychotropic drugs, electroshocks, the anaesthetics ketamine[3] and esketamine[4] or the psychedelic active ingredient of the mushroom psilocybin. Because of a physical dependence that develops over time, various withdrawal symptoms may occur upon discontinuation, especially with serotonin and serotonin-norepinephrine reuptake inhibitors (SRIs and SNRIs). Sandoz Pharmaceuticals from Switzerland writes about SRIs and SNRIs in their product characteristics summary for escitalopram:

"The most commonly reported reactions are dizziness, sensory disturbances (including paresthesias [unpleasant, sometimes painful bodily sensations with tingling, numbness, falling asleep of the limbs, cold and heat sensory disturbances], and electroshock-like sensations). Sleep disturbances (including insomnia and intense dreams), agitation or anxiety, nausea and/or vomiting, muscle tremors, confusion, sweating, headache, diarrhea, heart palpitations, emotional instability, irritability, and visual disturbances" (2021).

Such withdrawal symptoms cannot generally be avoided even with gradual discontinuation. They can also occur chronically, even with a time lag, i.e., only appearing some time after complete discontinuation. However, there is no diagnosis of drug dependence on either antidepressants or neuroleptics. Consequently, doctors can't tell if symptoms are from withdrawal, original issues, or rebound. Rebound symptoms are counter-regulatory adaptation reactions that lead to an increased recurrence of the original symptomatology upon discontinuation (Vetter 2023). There is also no diagnostic key for withdrawal symptoms. Physicians cannot bill health insurers for measures to manage them. Affected persons are not entitled to warning of withdrawal problems, to rehabilitation measures, to compensation for pain and suffering (Lehmann 2023b).

3 Marketed as Anket, KET, Ketalar, Ketamin, Ketamine, Ketavit, Kety, Rekita
4 Marketed as Esketamine, Spravato

Damage from electroshocks

Psychiatrists usually administer electroshocks, i.e. the triggering of epileptic seizures with jolts of electricity through the brain, in a series of 20-30 shocks, spread over a few days and weeks. To sufferers, they present electroshocks as safe treatments, as "electroconvulsive therapy" or "sleep therapy." Memory problems occurring after electroshocks would usually disappear on their own after about two weeks (Lehmann 2022).

The U.S. manufacturing company Somatics, LLC, next to the company Mecta the world's largest producer of electroshock apparatus, names in the product description of its apparatus Thymatron® System IV damage that it can cause, including "devastating cognitive consequences" (undated). Cognitive abilities include attention, memory, learning, creativity, planning, orientation, imagination, or will.

Somatics indicates that electroshocks can cause other damage. This includes memory impairment and brain damage, cardiac arrhythmias and myocardial infarction, general manic symptoms (for example, treatment-induced mania, post-traumatic delirium, or agitation), spontaneous seizures with time lags, sustained seizures, non-convulsive status epilepticus (a sequence of epileptic seizures between which the affected person does not return to the previous state and which are without clear tonic-clonic [i.e., alternating between rigidity and convulsive twitching]), pulmonary complications (e.g., aspiration of gastric contents, pneumonia, oxygen deficiency, airway obstruction such as laryngospasm, pulmonary embolism, prolonged respiratory failure), coma, homicide, and facilitation of suicidal behavior.

The percentage of electroshocked women is 70%. People over the age of 50 are also preferentially administered electroshocks.

Reduced life expectancy

Psychiatric diagnoses and corresponding treatment can decrease lifespan by 20-30 years (Aderhold 2007). This mortality has been rising continuously linearly at an alarming rate for decades (Saha et al. 2007). Janssen Pharmaceuticals, manufacturer of the neuroleptics haloperidol, paliperidone, and risperidone, among others, wrote in 2012:

> *"Research has shown that the life expectancy for people living with a serious mental health condition is, on average, 25 years shorter than the general population. Heart disease, diabetes, respiratory diseases, and infectious diseases (...) are the most common causes of death among this population."*

For some, the potentially toxic effects of psychotropic drugs are the cause of this catastrophe, for others the precarious living conditions under which the psychiatrically treated people, who often become unemployed, have to eke out their lives. If one were to regard – as is customary in mainstream psychiatry – the depressed state of health as

the causal factor for the frequent early deaths, then the question would actually arise as to whether there is still any justification for administering such risky agents to this vulnerable group of patients – regardless of whether formal or informal coercion is used.

Joe Parks, Chair of the Medical Directors Council of the U.S. National Association of State Mental Health Program Directors, pointed out the large number of people dying early "with severe mental illness" years before Janssen Pharmaceuticals. Those are people with diagnoses such as "schizophrenia," "bipolar disorder," "major depression" and "personality disorder," meaning people who receive neuroleptics and antidepressants in particular. Parks warned:

> *"It has been known for several years that persons with serious mental illness die younger than the general population. However, recent evidence reveals that the rate of serious morbidity (illness) and mortality (death) in this population has accelerated. In fact, persons with serious mental illness (SMI) are now dying 25 years earlier than the general population"* (2006).

Together with his colleagues, Parks mentioned the connection of premature mortality specifically with the so-called atypical neuroleptics and their dangerous adverse effects. He warned about the risks of weight gain, diabetes, dyslipidemia, insulin resistance (lack of or severely reduced cellular response to insulin), and metabolic syndrome (combination of obesity, insulin resistance, dyslipidemia and hypertension).

The example of neuroleptic malignant syndrome (NMS), a complex of symptoms associated with fever, muscle stiffness and clouding of consciousness, will be used to illustrate how such psychotropic drug effects are quantified. This is considered an adverse effect of neuroleptics and antidepressants and has a high lethality rate. The individual symptoms do not have to be particularly pronounced; the state of consciousness of the affected person can fluctuate between light drowsiness and coma. Depot neuroleptics, whose effect cannot be stopped if the worst comes to the worst, represent a particular risk factor:

> *"NMS occurs in most cases within two weeks of the onset of neuroleptic medication, but there are reports of years of latency (periods of symptomlessness). Symptoms develop to full intensity within one to three days and extend for a total of five to ten days; if a depot neuroleptic is the precipitating agent, courses two to three times as long are also observed. The lethality rate is high..."* (Tornatore et al. 1991, p. 37).

In the mid-1980s, certain psychiatrists, as well as the U.S. Psychiatric Association, estimated that 20% to 30% of sufferers die once NMS has developed (Lehmann 1996, p. 98). The English psychologist David Hill wrote in 1992:

> *"Estimates place the incidence of NMS between 0.2 per cent and 1.4 per cent of major tranquilizer recipients. Between 19 per cent and 30 per cent die within a few days. The most conservative estimates (0.2 per cent and 19 per cent) suggest roughly one million cases of NMS to date, of which about 199,000 have been fatal"* (p. 35).

Peter Gøtzsche gave a similar figure to diabetes caused by the neuroleptic drug olanzapine.[5] This specialist in internal medicine and in 1993 co-founder of the Cochrane Collaboration, an international network of scientists and physicians oriented to the principles of so-called evidence-based medicine, estimated in his book *Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare* (2014) – without, however, disclosing the basis of his calculation –,

> *"... that 200,000 of the 20 million patients treated with Zyprexa have died from the adverse effects of the drug. What is particularly sad about this is that many of these patients should never have been treated with Zyprexa. Since Zyprexa is not the only drug, the number of victims must be even higher."*

Who is brave enough to calculate the number of people who have died from the adverse effects of prescribed antidepressants and neuroleptics to date?

Infringement of bodily inviolability by administration of psychotropic drugs and electroshocks without legally effective informed consent

Medical interventions of all kinds, including the administration of psychotropic drugs or electroshocks, are considered bodily harm under criminal law. They lose the character of criminal offence only by informed consent, by consent by advance directive or in case of acute danger to life. In general, psychiatrists do not inform: not at the time of administration, not in the further course of treatment, not in the transition to long-term treatment.

Studies, such as the European study "Discrimination against psychiatric patients in the health care system," co-organized by independent (ex-) users and survivors of psychiatry, demonstrated this. The study was conducted under the framework of the "Community Action Program to Combat Discrimination 2001-2006," funded by the European Commission and carried out by associations of psychiatric professionals, relatives, and (ex-) users and survivors of psychiatry. The surveys in Great Britain, Austria, Germany, Spain and the Netherlands brought this result:

5 Marketed as Dopin Tab, Hiolanz, Jolyon-MD, Joyzol, Jubrexa, Lanazyp, Lanopin, Olancer, Olancor, Olankline, Olanzapin, Olanzapine, Olanzavitae, Olanzine, Olazax, Onzapin, Ozapram, Prexolan, Rolyprexa, Tevatiapine, Tolanz, Xepat, Zalasta, Zolanz, Zozapin, Zypadhera, Zypine, Zyprexa

> *"Psychiatric drugs are prescribed without informed consent. Complaints are dismissed as part of pathology. (…) Patients are threatened with discharge, separation, forced treatment or enhancement of the psychiatric drugs' dose, if they do not accept the offered treatment"* (Action Project 2005).

Manufacturing companies like to withhold information about the harmful effects of their products. If necessary, they may even be sued for millions of dollars in damages and compensation for pain and suffering – as in the Zyprexa case, when the company Eli Lilly did not immediately inform patients that its product could cause diabetes. The drug firm had to pay about US$ 1.2 billion to settle civil lawsuits and US$ 1.4 billion to settle federal lawsuits (Berenson 2007; Department of Justice 2009; Gottstein 2020).

If patients are not informed comprehensively and understandably about the risks, dangers and alternatives of the treatments offered, they cannot give legally effective consent to their use, and the treatment remains a punishable bodily injury in some states (Gottstein 2023). Gerhard Gründer, the former chairperson of the Task Force Psychopharmacology of the German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology (DGPPN), acknowledged that doctors are not providing patients with the required information about the risks of antidepressants and neuroleptics. He, in his own words, had spent many years as a specialist and senior physician

> *"... argued that my patients would stop taking their medication if I informed them of all the side effects, complications and tardive effects"* (2022, p. 4).

There is nothing to suggest that this psychiatrist differs from his psychiatric colleagues solely in terms of his openness about his rights violations, in other words, that psychiatric administration of psychotropic drugs and electroshock, whether with formal or "only" informal coercion, is a systematic human rights violation. I wonder if at some point government agencies will proactively address this massive violation of the UN CRPD?

Withholding information about the risks of physical dependence on antidepressants and neuroleptics

To legally consent to taking psychotropic drugs, people must be fully informed about the risks and dangers of these drugs as well as alternatives of treatments. Discontinuation and withdrawal problems which might occur later are an integral part of those risks and dangers.

Rudolf Degkwitz, director of a psychiatric university hospital from 1960 to 1987 and president of the German Society for Psychiatry and Neurology (DGPN) in 1971/72, was the first psychiatrist in Germany to provide specific information about the risk

of drug dependence with neuroleptics and antidepressants. In 1967, he wrote about psycholeptics, which includes antidepressants and neuroleptics:

> *"The reduction or discontinuation of psycholeptics leads (...) to considerable withdrawal symptoms, which are in no way different from the withdrawal symptoms following the discontinuation of alkaloids and sleeping pills"* (p. 161).

The chemical group of alkaloids includes, for example, morphine well-known for its potential to build dependency. The symptoms of morphine withdrawal syndrome include tremor, diarrhoea, vomiting, nausea, restlessness, anxiety, seizures, insomnia, delirium, states of twilight or bad mood, but above all life-threatening circulatory disorders with shock states. Sleeping pills also build dependency. Their withdrawal can also bring major problems, including life-threatening seizures. Gründer warned of a vicious circle that can arise from continued neuroleptic drug use – not publicly, but in his technical book addressed to his colleagues:

> *"The development of supersensitive dopaminergic systems illustrates the dilemma of antipsychotic pharmacotherapy: Every treatment with D2-receptor antagonists (substances directed against the action of dopamine2) potentially carries the risk that supersensitivity of the target receptors will develop. However, once this has occurred, a vicious circle of tolerance development, dose increase and further progression of the pathophysiological process often follows"* (2022b, p. 70).

They withheld this warning from those affected and their relatives. It also does not appear in any manufacturer's summary of product characteristics to the medical profession.

Misinformation about withdrawal risks and opportunities

With few exceptions, drug firms and psychiatrists inform treatment candidates that antidepressants and neuroleptics do not cause physical dependence and can therefore be discontinued relatively easily. Reports of massive withdrawal problems (see, e.g., Lehmann 2023a) are inflated accounts by laypersons, anecdotal individual cases, the consequence of discontinuing too quickly, or indications of the return of the original psychological problem. Moreover, the causes of persistent withdrawal problems in particular are not known, and above all: there is no craving for addiction to antidepressants or neuroleptics, neither in humans nor in laboratory animals. Addiction, however, would have to be present for one to speak of dependence. With this new linguistic definition of dependency, which was agreed upon at the suggestion of the pharmaceutical industry in 1996 and which was adopted by psychiatric organizations, the latter want to evade responsibility for the damage they cause (Lehmann 2023b).

Refusal to help with withdrawal from psychotropic drugs

Psychiatrists do not learn how to discontinue antidepressants and neuroleptics at low risk. Instead, they usually believe in the necessity of lifelong administration. They send patients away who seek support for discontinuation, as experience has shown. Or the psychiatrists pretend to discontinue, but merely replace one psychotropic drug with another. Often they discontinue far too quickly according to manufacturers' summaries of product characteristics that do not correspond to the findings of medical science and thus violate medicines acts, for example, the Section 84(1)(2) of the German Medicines Act7 (Langfeldt 2023), thus triggering massive withdrawal problems and relapses into psychiatrization.

Misinformation about dependence and withdrawal problems, refused or incompetent help with withdrawal, failed withdrawal attempts and physical dependence with its consequential damage are likely to result in economic damage running into billions. It is to be hoped that at some point health economists will feel called upon to calculate the economic damage and make it public. Besides the costs of administering treatment, there are also expenses related to caring for those who have been damaged, such as sheltered workshops, assisted living, and retirement. And besides the material damage, there is also the immaterial damage associated with the reduced life expectancy because of the administration of potentially toxic substances, mostly to physically vulnerable people from the outset, and with a massive loss of their quality of life and the quality of life of their families. All this is closely related to the long-term administration of dependence-causing substances.

Human rights-based support

Worldwide, people are asking for respectful and compassionate support for those who want to stop taking psychotropic drugs or seek humanistically oriented support ("milder remedies") without being in danger of being forcibly administered psychotropic drugs and electroshocks. Such human rights-based assistance is also urgently needed to reach the United Nations' Sustainable Development Goal 3 (SDG3) of the 2030 Agenda for Sustainable Development: to reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being for all at all ages (Lehmann 2019).

Non-psychopharmacological and human rights-oriented assistance for people in emotional distress

In his capacity as United Nations Special Rapporteur on the Right to Health, the Lithuanian psychiatrist Dainius Pūras criticized the dominance of the pharmaceutical industry in the mental health system in his 2017 report on the universal right of access to the highest attainable standard of physical and mental health:

> *"However, the field of mental health continues to be over-medicalized and the reductionist biomedical model, with support from psychiatry and the pharmaceutical industry, dominates clinical practice, policy, research agendas, medical education and investment in mental health around the world. The majority of mental health investments in low-, middle- and high-income countries disproportionately fund services based on the biomedical model of psychiatry. There is also a bias towards first-line treatment with psychotropic medications, in spite of accumulating evidence that they are not as effective as previously thought, that they produce harmful side effects and, in the case of antidepressants, specifically for mild and moderate depression, the benefit experienced can be attributed to a placebo effect. Despite those risks, psychotropic medications are increasingly being used in high-, middle- and low-income countries across the world. We have been sold a myth that the best solutions for addressing mental health challenges are medications and other biomedical interventions"* (United Nations 2017, pp. 5-6).

Both, in circles of professionally active people and in the public, the upcoming realization would be important that psychiatry as a medical (and scientific) discipline, which admits actions against the will of people in crisis as a permissible option, doesn't live up to the claim of solving mental problems of a predominantly social nature, even with presumably "good intentions." Examples of milder means, i.e., refraining from formal and informal psychiatric coercion, you can find in reports on the Diabasis Project in the U.S. (Perry 1980), the Soteria approach (Aderhold et al. 2007), the Weglaufhaus in Berlin (Kempker 1998; Hartmann & Bräunling 2007), and especially on Open Dialogue ("need-adapted treatment") in Finland (Seikkula & Alakare 2007) and the Crisis Hostel in the U.S. (Dumont & Jones 2007).

Possibilities of low-risk withdrawal from psychotropic drugs

Returning to the UN Convention on the Rights of Persons with Disabilities, in 2015 the UN Human Rights Council's Working Group on Arbitrary Detention called for effective legal protection for persons with disabilities, which, to reiterate, include people with psychiatric diagnoses. In its report to the United Nations General Assembly, the Working Group called for special support programs:

> *"Such assistance programmes should not be centred on the provision of mental health services or treatment, but free or affordable community-based services, including alternatives that are free from medical diagnosis and interventions. Access to medications and assistance in withdrawing from medications should be made available for those who so decide"* (Working Group on Arbitrary Detention 2015, p. 25 – Emphasis P.L.).

In the same year, this requirement was included in the same wording in Guideline 14 ("The right to liberty and security of persons with disabilities") of the CRPD (2015).

As the state health administrations and the organisations of professionals in the mental health field remain completely inactive, meanwhile even the World Health Organisation and the High Commissioner for Human Rights of the United Nations demand a much higher standard of informed consent as well as repeatedly support programmes for low-risk withdrawal from psychotropic drugs.

> *"Countries should adopt a higher standard for the free and informed consent to psychotropic drugs given their potential risks of harm in the short and long term. Countries, for example, can require written or documented informed consent (e.g. expressed by a recording in video or audio formats) after providing detailed information on potential negative and positive effects, and the availability of alternative treatment and non-medical options. Legislation can require medical staff to inform service users about their right to discontinue treatment and to receive support in this. Support should be provided to help people safely withdraw from treatment with drugs"* (WHO & OHCHR 2023, p. 57 – Emphasis P.L.).

Millions of people who are prescribed psychotropic drugs, especially antidepressants and neuroleptics, are still far away from such support programs – in Germany, in Greece and all over the world. Yet there are individual initiatives of organized help with withdrawal, be it in line with the "Guidelines for Depression Therapy in Adults" of the British National Institute for Health and Care Excellence (RCP, undated), the call of politicians, experts, and patient representatives for the UK government to reverse the rate of antidepressant prescribing (BMJ 2023), structured psychiatric help with withdrawal including accompaniment in withdrawal-related crises in Germany (Gonther 2023; Zinkler 2023), thoughtful peer support for withdrawal in Canada (Cyr 2023), or collaborative support for withdrawal by the Thessaloniki Observatory for Human Rights in the Mental Health Field (Emmanouelidou 2023). The best possible support and publicity should be given to such lighthouse projects!

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References

1. Action Project against "Harassment and Discrimination Faced by People with Mental Health Problems in the Field of Health Services" (2005): *Main findings on harassment and discrimination in health and mental health services.* Back of the anti-discrimination poster of the European Commission's study "Harassment and Discrimination Faced by People with Psycho-social Disability in Health Services – A European Survey" in the framework of the "Community Action Programme to combat discrimination 2001-2006", Brussels. Online resource http://www.peter-lehmann-publishing.com/articles/enusp/pdf/poster-e-1.pdf
2. Aderhold, Volkmar (2007): Mortalität durch Neuroleptika. *Rundbrief des Bundesverbands Psychiatrie-Erfahrener, No. 3, pp.* 11-15. Online resource https://www.antipsychiatrieverlag.de/artikel/gesundheit/aderhold.htm
3. Aderhold, Volkmar / Stastny, Peter / Lehmann, Peter (2007): Soteria: An alternative mental health reform movement (pp. 146-160). In: Peter Stastny & Peter Lehmann (eds.), *Alternatives beyond psychiatry*. Berlin, Eugene & Shrewsbury: Peter Lehmann Publishing (E-book 2022)
4. Beauftragter der Bundesregierung für die Belange von Menschen mit Behinderung (November 2018): *Die UN-Behindertenrechtskonvention – Übereinkommen über die Rechte von Menschen mit Behinderungen. Die amtliche, gemeinsame Übersetzung von Deutschland, Österreich, Schweiz und Lichtenstein*. Online publication https://www.institut-fuer-menschenrechte.de/fileadmin/Redaktion/PDF/DB_Menschenrechtsschutz/CRPD/CRPD_Konvention_und_Fakultativprotokoll.pdf
5. Berenson, Alex (January 5, 2007): Lilly settles with 18,000 over Zyprexa. *The New York Times*. Online edition https://www.nytimes.com/2007/01/05/business/05drug.html
6. BMJ – British Medical Journal (December 5, 2023): Politicians, experts, and patient representatives call for the UK government to reverse the rate of antidepressant prescribing. *British Medical Journal*, Vol. 383, p2730; DOI: 10.1136/bmj.p2730. Electronic publication https://www.bmj.com/content/383/bmj.p2730
7. Bundesärztekammer (2023): Ethische und rechtliche Fragen der Behandlung von Nicht-Einwilligungsfähigen: Zwang bei gesundheitlicher Selbstgefährdung. *Deutsches Ärzteblatt*, Vol. 120, No. 21-22, edition A, pp. 1-3. Online resource https://www.bundesaerztekammer.de/fileadmin/user_upload/BAEK/Themen/Recht/Bekanntmachung_BAEK_Ethische_und_rechtliche_Fragen.pdf
8. Committee on the Rights of Persons with Disabilities (2015): *Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities – The right to liberty and security of persons with disabilities*. Online resource https://www.ohchr.org/sites/default/files/Documents/HRBodies/CRPD/14thsession/GuidelinesOnArticle14.doc

9. Cyr, Céline (2023): Learning, questioning psychiatric drugs, and withdrawal by way of GAM peer support. In: Peter Lehmann & Craig Newnes (eds.), *Withdrawal from prescribed psychotropic drugs*. Updated e-book edition. Berlin & Lancaster: Peter Lehmann Publishing (Print edition: Lancaster: Egalitarian Publishing 2023, pp. 220-235)
10. Degkwitz, Rudolf (1967): *Leitfaden der Psychopharmakologie*. Stuttgart: Wissenschaftliche Verlagsgesellschaft
11. Department of Justice (January 15, 2009): *Eli Lilly and Company agrees to pay $1.415 billion to resolve allegations of off-label promotion of Zyprexa. $515 million criminal fine is largest individual corporate criminal fine in history; civil settlement up to $800 million*. Press release. Online resource https://psychrights.org/Articles/090115DoJMediaReleaseReLillySettlement.pdf
12. Dumont, Jeanne / Jones, Kristine (2007): The Crisis Hostel: Findings from a consumer/survivor-defined alternative to psychiatric hospitalization (pp. 179-187). In: Peter Stastny & Peter Lehmann (eds.), *Alternatives beyond psychiatry*. Berlin, Eugene & Shrewsbury: Peter Lehmann Publishing (E-book 2022)
13. Emmanouelidou, Anna (2023): Cooperative support in withdrawal from psychiatric drugs. The model of the Observatory for Human Rights in the Mental Health Field, Thessaloniki (pp. 296-307). In: Peter Lehmann & Craig Newnes (eds.), *Withdrawal from prescribed psychotropic drugs*. Updated e-book edition. Berlin & Lancaster: Peter Lehmann Publishing (Print edition: Lancaster: Egalitarian Publishing 2023, pp. 211-219)
14. Fava, Giovanni Andrea (2021): *Discontinuing antidepressant medications*. Oxford: Oxford University Press
15. Fava, Giovanni Andrea / Offidani, Emanuela (August 20, 2011): The mechanisms of tolerance in antidepressant action. *Progress in Neuro-Psychopharmacology & Biological Psychiatry*, Vol. 35, pp. 1593-1602
16. Gøtzsche, Peter C. (2014): *Tödliche Medizin und organisierte Kriminalität – Wie die Pharmaindustrie das Gesundheitswesen korrumpiert*. Munich: Riva Verlag (English edition: *Deadly medicines and organised crime: How Big Pharma has corrupted healthcare*. Boca Raton, FL: CRC Press 2013)
17. Gonther, Uwe (2023): Psychopharmakareduktion in der psychiatrischen Klinik – der Bremer Weg. In: Peter Lehmann & Craig Newnes (eds.), *Psychopharmaka reduzieren und absetzen – Praxiskonzepte für Fachkräfte, Betroffene, Angehörige* (pp. 130-138). Berlin & Lancaster: Peter Lehmann Antipsychiatrieverlag / Cologne: Psychiatrieverlag
18. Gottstein, Jim (2020): *The Zyprexa Papers.* Anchorage, AK: Jim Gottstein
19. Gottstein, James (Jim) B. (2023): The prospect of recovering compensation for psychiatric drug withdrawal harm through litigation because of missing or misleading information (pp. 427-438). In: Peter Lehmann & Craig Newnes (eds.), *Withdrawal from prescribed psychotropic drugs*. Updated e-book edition. Berlin & Lancaster: Peter Lehmann Publishing (Print edition: Lancaster: Egalitarian Publishing 2023, pp. 320-328)
20. Gründer, Gerhard (2022): *Psychopharmaka absetzen? Warum, wann und wie?* Munich: Verlag

Urban & Fischer in Elsevier

21. Hartmann, Petra / Bräunling, Stefan (2007): Finding common strength together: The Berlin Runaway House (pp. 188-199). In: Peter Stastny & Peter Lehmann (eds.), *Alternatives beyond psychiatry*. Berlin, Eugene & Shrewsbury: Peter Lehmann Publishing (E-book 2022)
22. Hill, David (October 1992): Major tranquillizers: A good buy? *Clinical Psychology Forum*, pp. 35-36
23. Info Extra (February 2000): Wahrnehmung von Zwang in der Psychiatrie. Alternativen und Perspektiven. *Info Extra* (Magazine of the Verein für SACHwalterschaft & PATIENTENanwaltschaft, Vienna), p. 39. Online resource https://www.antipsychiatrieverlag.de/artikel/recht/lexikon_zwang.htm
24. Janssen Pharmaceuticals, Inc. (2012): The importance of total wellness. *Choices in Recovery – Support and Information for Schizophrenia, Schizoaffective, and Bipolar Disorder*, Vol. 9, No. 2, p. 12
25. Kempker, Kerstin (ed.) (1998): *Flucht in die Wirklichkeit – Das Berliner Weglaufhaus*. Berlin: Peter Lehmann Antipsychiatrieverlag
26. Langfeldt, Marina (2023): Strict liability according to § 84 of the Medicinal Products Act on the basis of summaries of product characteristics for antidepressants or neuroleptics without information concerning discontinuation (pp. 305-319). In: Peter Lehmann & Craig Newnes (eds.), *Withdrawal from prescribed psychotropic drugs*. Updated e-book edition. Berlin & Lancaster: Peter Lehmann Publishing (Print edition: Lancaster: Egalitarian Publishing 2023, pp. 305-319)
27. Lehmann, Peter (1996): *Schöne neue Psychiatrie*, Vol. 2: *Wie Psychopharmaka den Körper verändern*. Berlin: Peter Lehmann Antipsychiatrieverlag (E-book 2022)
28. Lehmann, Peter (September 6, 2015): *Der Mensch als Tier – Über Parallelen beim Herztod in zoologischer Gefangenschaft und in der Psychiatrie*. Online publication https://www.antipsychiatrieverlag.de/artikel/gesundheit/herztod.htm
29. Lehmann, Peter (2017): Risiken und Schäden neuer Antidepressiva und *atypischer* Neuroleptika (pp. 19-174). In: Peter Lehmann, Volkmar Aderhold, Marc Rufer et al., *Neue Antidepressiva, atypische Neuroleptika – Risiken, Placebo-Effekte, Niedrigdosierung und Alternativen. Mit einem Exkurs zur Wiederkehr des Elektroschocks*. Berlin & Shrewsbury: Peter Lehmann Publishing (E-book 2023)
30. Lehmann, Peter (2019): Paradigm shift: Treatment alternatives to psychiatric drugs, with particular reference to low- and middle-income countries (pp. 251-269). In: Laura Davidson (ed.), *The Routledge Handbook of International Development, Mental Health and Wellbeing*. London & New York: Routledge. Online resource http://www.peter-lehmann-publishing.com/articles/lehmann/pdf/sdg3-psychiatry-treatment-alternatives.pdf
31. Lehmann, Peter (2022): A concise guide to electroshock: Indications, mode of action, risks, alternatives. *Journal of Critical Psychology, Counselling and Psychotherapy*, Vol. 22, No. 3, pp. 36-45. Online resource http://www.peter-lehmann-publishing.com/articles/lehmann/pdf/lehmann-eshock.pdf

32. Lehmann, Peter (2023a): *Jeder leidet für sich allein – Berichte über das chronische Entzugssyndrom bei Antidepressiva*. Online resource https://www.peter-lehmann.de/chronisches-antidepressiva-entzugssyndrom.htm
33. Lehmann, Peter (2023b): For or against dependence on antidepressants and neuroleptics: Who benefits? (pp. 76-125). In: Peter Lehmann & Craig Newnes (eds.), *Withdrawal from prescribed psychotropic drugs*. Updated e-book edition. Berlin & Lancaster: Peter Lehmann Publishing (Print edition: Lancaster: Egalitarian Publishing 2023, pp. 45-76)
34. Natterson-Horowitz, Barbara / Bowers, Kathryn (2014): *Wir sind Tier – Was wir von den Tieren für unsere Gesundheit lernen können*. Munich: Knaus Verlag (English edition: *Zoobiquity: The astonishing connection between human and animal health*. New York: Vintage 2013)
35. Parks, Joe (October 2006): Foreword (p. 4). In: Joe Parks, Dale Svendsen, Patricia Singer et al. (eds.), *Morbidity and mortality in people with serious mental illness*. Alexandria, VA: National Association of State Mental Health Program Directors, Medical Directors Council. Online publication https://www.nasmhpd.org/sites/default/files/2022-08/Mortality%2520and%2520Morbidity%2520Final%2520Report%25208.18.08_0.pdf
36. Perry, John Weir (1980): Psychosis as visionary state (pp. 193-198). In: Ian F. Baker (ed.), *Methods of treatment in analytical psychology*. Fellbach: Bonz Verlag
37. RCP – Royal College of Psychiatrists (undated): *Stopping antidepressants*. Online resource https://www.rcpsych.ac.uk/docs/default-source/mental-health/treatments-and-wellbeing/print-outs/stopping-antidepressant-printable.pdf?sfvrsn=2c9a63e0_2
38. Saha, Sukanta / Chant, David / McGrath, John (2007): A systematic review of mortality in schizophrenia: Is the differential mortality gap worsening over time? *Archives of General Psychiatry*, Vol. 64, pp. 1123-1131
39. Sandoz Pharmaceuticals AG (April 2021): Escitalopram Sandoz®. Risch: Summary of product characteristics. In: *Arzneimittel-Kompendium der Schweiz*. Berne: HCI Solutions AG. Online resource https://compendium.ch/product/1237654-escitalopram-sandoz-filmtabl-5-mg/mpro
40. Schlötterer, Wilhelm (2021): *Staatsverbrechen – der Fall Mollath. Das vorsätzliche Verbrechen an Gustl Mollath zwischen Schwarzgeld-Millionen, Vertuschung und der Rolle der CSU*. Munich: FinanzBuch Verlag
41. Schönenberger, Edmund (1993): Zwangspsychiatrie in der Schweiz – was tun? (pp. 183-194). In: Kerstin Kempker & Peter Lehmann (eds.), *Statt Psychiatrie*. Berlin: Peter Lehmann Antipsychiatrieverlag. Online resource https://www.antipsychiatrieverlag.de/artikel/recht/schoenenberger.htm
42. Seikkula, Jaakko / Alakare, Birgitta (2007): Open Dialogue (pp. 223-239). In: Peter Stastny & Peter Lehmann (eds.), *Alternatives beyond psychiatry*. Berlin, Eugene & Shrewsbury: Peter Lehmann Publishing (E-book 2022)
43. Somatics, LLC – the Makers of the Thymatron® (undated): *Thymatron® System IV – Cautions and Warnings*. Venice, FL: Somatics, LLC. Online resource http://www.thymatron.com/

catalog_cautions.asp

44. Tornatore, Frank L. / Sramek, John J. / Okeya, Bette L. et al. (1991): *Unerwünschte Wirkungen von Psychopharmaka*. Stuttgart / New York: Thieme Verlag (English edition: *Reactions to psychotropic medication*. New York & London: Plenum Pub Corp. 1987)
45. United Nations (2006): Convention on the Rights of Persons with Disabilities. Online resource https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html
46. United Nations (March 13, 2013): Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez. Report A/HRC/22/53/Add.4 to the Human Rights Council, twenty-second session, agenda item 3. Online resource https://digitallibrary.un.org/record/745883?v=pdf
47. United Nations (May 5, 2014): Committee on the Rights of Persons with Disabilities. Eleventh Session. General Comment No. 1. Article 12: Equal Recognition before the Law. Document CRPD/C/GC/1. Online resource https://undocs.org/CRPD/C/GC/1
48. United Nations (January 31, 2017): Report of the United Nations High Commissioner for Human Rights. Report A/HRC/34. Online resource https://www.un.org/disabilities/documents/reports/ohchr/a_hrc_34_32_mental_health_and_human_rights_2017.docx
49. United Nations (June 6-23, 2017): Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report A/HRC/35/21 to the Human Rights Council, thirty-fifth session, agenda item 3. Online resource https://undocs.org/A/HRC/35/21
50. United Nations – Convention on the Rights of Persons with Disabilities, Committee on the Rights of Persons with Disabilities (October 29, 2019): Concluding observations on the initial report of Greece. Document lCRPD/C/GRC/CO/1.
51. Vetter, Stefan (2023): Umgang mit Reboundeffekten beim Absetzen von Psychopharmaka (pp. 179-187). In: Peter Lehmann & Craig Newnes (eds.), Psychopharmaka reduzieren und absetzen – Praxiskonzepte für Fachkräfte, Betroffene, Angehörige (pp. 130-138). Berlin & Lancaster: Peter Lehmann Antipsychiatrieverlag / Cologne: Psychiatrieverlag
52. WHO – World Health Organization / OHCHR – Office of the United Nations High Commissioner for Human Rights (2023): Mental health, human rights and legislation. Guidance and practice. Geneva: WHO / OHCHR. Online resource https://www.who.int/publications/i/item/9789240080737
53. Working Group on Arbitrary Detention (July 6, 2015): Report to the United Nations, General Assembly, Thirtieth session, agenda item 3 (Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development). Document A/HRC/30/37. Online resource https://www.ohchr.org/en/documents/thematic-reports/ahrc3037-united-nations-basic-principles-and-guidelines-remedies-and
54. Zinkler, Martin (2023): Institutional support in crises during discontinuation of psychiatric drugs (pp. 226-236). In: Peter Lehmann & Craig Newnes (eds.), Withdrawal from

prescribed psychotropic drugs. Updated e-book edition. Berlin & Lancaster: Peter Lehmann Publishing (Print edition: Lancaster: Egalitarian Publishing 2023, pp. 165-172)

55. Zinkler, Martin / von Peter, Sebastian (2019): Ohne Zwang – ein Konzept für eine ausschließlich unterstützende Psychiatrie. Recht und Psychiatrie, Vol. 37, pp. 203-209

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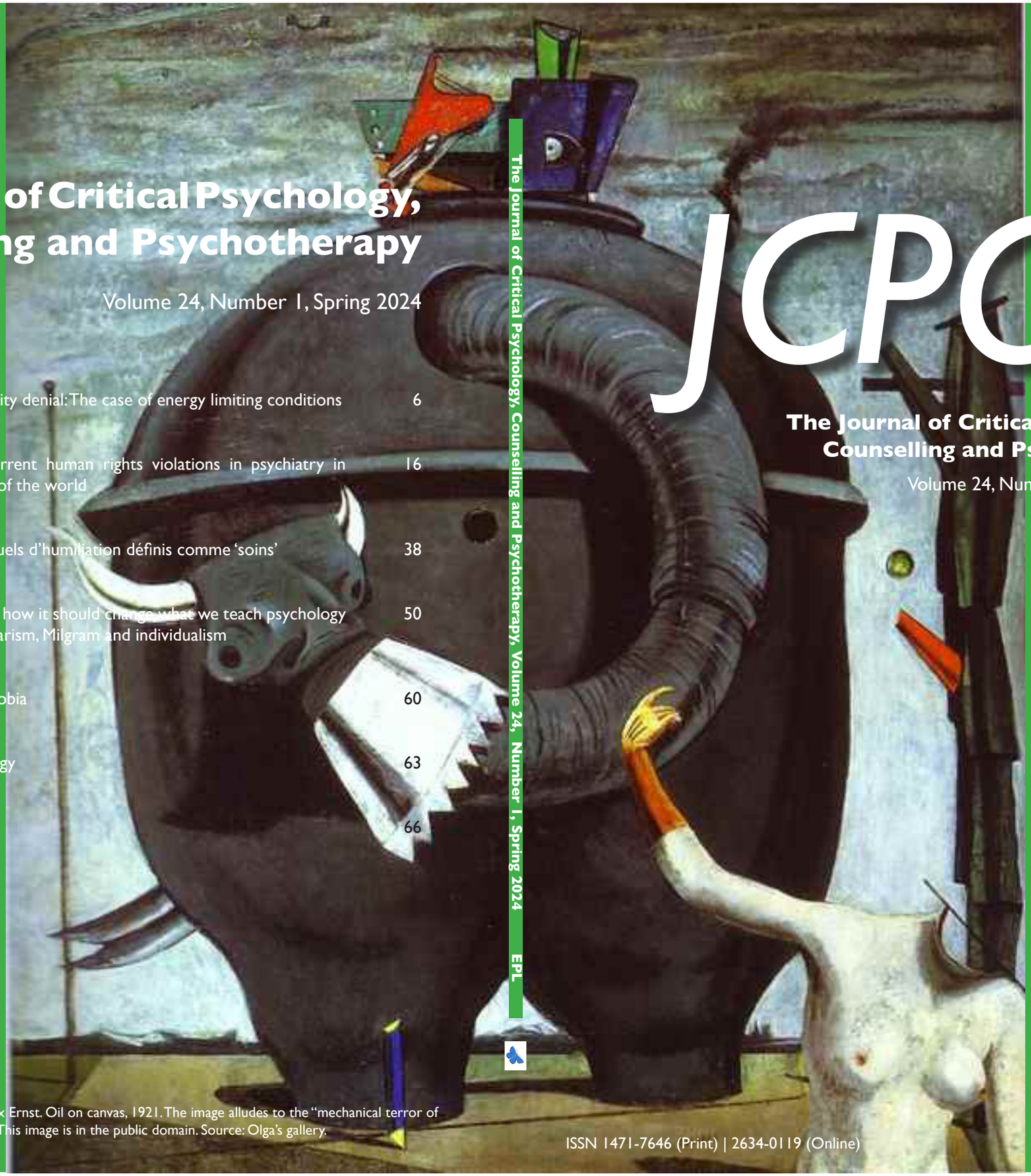

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