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"I Didn't Feel Valid as a Human Being": A Gendered Analysis of Women's Experiences and Resistances to Involuntary Mental Health Treatment

Chantel Bakac
BSW (Hons)
University of Sydney

Abstract

Involuntary mental health treatment is when a person undergoes an unwanted intervention in a hospital or in the community due to an authorised medical officer deeming the person to be 'mentally ill' or 'mentally disordered' (NSW Government, 2021). *The Mental Health Act NSW* (2007) frames involuntary mental health treatment as a 'necessary' and 'effective' approach to supporting people experiencing mental distress. This study critically engages with women's experiences of involuntary mental health treatment, exploring the potential implications of a biomedical and carceral response to women's distress. Six women with experience of involuntary mental health treatment in NSW were involved in my Honours project. In alignment with both feminist and critical mental health frameworks, semi-structured, in-depth interviews were chosen as they provide a loose structure and allow for flexibility to discover new areas of significance identified by women (Dcruz & Jones, 2013). The project was approved by the University of Sydney Human Ethics Committee.

All women involved in this study described involuntary mental health treatment as a profoundly harmful experience which produced ongoing implications. Women described the ways in which psychiatric and gender oppressions intersected to perpetuate the silencing of women. Collectively and individually, all women displayed acts of resistance towards psychiatric and patriarchal hegemony. Three major themes were identified in the analytical process: The Censorship of Knowledge; The Censorship of Emotions; and The Censorship of Acts of Resistance.

Keywords: women; involuntary mental health treatment; oppression; resistance;

Introduction

Involuntary mental health treatment is when a person undergoes an unwanted intervention in a hospital or in the community due to an authorised medical officer deeming the person to be ‘mentally ill’ or ‘mentally disordered’ (NSW Government, 2021). *The Mental Health Act NSW* (2007) frames involuntary mental health treatment as a ‘necessary’ and ‘effective’ approach to supporting people experiencing mental distress. This study critically engages with women’s experiences of involuntary mental health treatment, exploring the potential implications of a biomedical and carceral response to women’s distress. Whilst there has been research conducted on the gendered oppressions women may be subjected to when engaging with voluntary mental health services, a gendered lens has not been applied to involuntary contexts to the same extent (Archer et al., 2016; Ross, 2018). As involuntary mental health treatment is common, a range of possible gendered harms are in urgent need of detailed exploration (Moulding, 2015; Tseris et al., 2022). Australia has the second highest rates of involuntary psychiatric hospitalisations when compared to admission rates across Europe and New Zealand (Australian Institute of Health and Welfare [AIHW], 2023). In Australia during 2020-21, 56% of admissions to an acute mental health hospital were on an involuntary basis, specifically 39% of involuntary days for women (AIHW, 2023). Within this study, *woman* is defined as any person who self-identifies as a woman; acknowledging that gender can be seen on a continuum beyond the binary of male and female (Vaid-Menon, 2020). This paper seeks to understand a diverse range of women’s experiences and resistances to involuntary mental health treatment in New South Wales (NSW), Australia, by centring lived experience voices.

Positionality

Fook’s (1999) theorisation of reflexivity highlights the importance of locating oneself in the research to be self-aware of ones’ own power and privilege. I bring an etmic positionality to the research, a combination of etic (insider) and emic (outsider) (Helfrich, 1999). I have been a peer worker in involuntary inpatient and community mental health settings across South Western Sydney and drew upon direct experiences of gendered harms in such contexts. I do not claim to represent the diverse voices of all women who have experienced involuntary mental health treatment. I also come into this project as a humble learner, as a social work student, on the opposite end of the system. Some may consider my positionality to be polemical. However, as this project is located outside of positivist research, I challenge the assumption that research is a neutral process whereby one universal truth can be uncovered by an uninvolved researcher (Lather, 2004). As such, my positionality disrupts the power imbalance between the researcher as a distant ‘expert’ and the ‘patient’ who is the ‘object’ to avoid replicating the power differentials involved in involuntary assessment processes (Ackerly & True, 2020; Lenette, 2022).

Literature Review

The purpose of this literature review was to look at the scholarly landscape of involuntary mental health treatment, including the impact of biomedical and neoliberal paradigms, the use of censorship in involuntary mental health settings, and the relevance of a gendered lens. This includes national and international scholarship, with a focus on Australian literature, where possible. In doing so, the study’s aim of understanding women’s experiences and resistances to involuntary mental health treatment in NSW, Australia, has been contextualised.

Research on the Impact of Involuntary Mental Health Treatment

Involuntary mental health treatment operates under the stated intentions in *The Mental Health Act 2007* (NSW) of acting in the person’s ‘best interests’, despite such discourse being problematised through critical literature (Cohen, 2017; Jordan et al., 2019; Maylea, 2017; McKeown, 2019; Soros, 2021). The World Health Organization and the United Nations (WHO & UN, 2023) alongside critical mental health scholars, have labelled involuntary mental health treatment as a human rights violation (Daley et al., 2019; Lee-Evoy, 2019; Probert, 2021; Tseris et al., 2022; Watson, 2020). This is due to a denial of agency through forced treatment and coercive practices, including physical, mechanical, and medical restraint, seclusion, and confinement in locked wards (McKeown et al., 2019; Prytherch et al., 2021). Whilst the need for involuntary treatment goes largely unquestioned by society at large (Tseris et al., 2022), the extant literature challenges the belief that such a response is always in people's 'best interests', rather suggesting that the impact of involuntary treatment may lead to the amplification of distress (Fullagar et al., 2019; Tseris, 2017a). A study by Jordan & McNiel (2019) found that psychiatric coercion may increase suicidal ideation and attempts, thus challenging the notion of involuntary treatment preventing risk of harm. Despite this argument, involuntary treatment continues to be the dominant response to acute mental distress (AIHW, 2023; Read & Harper, 2020).

Research on the Impact of Biomedical and Neoliberal Paradigms

In an involuntary mental health setting, the biomedical paradigm, which focuses on individual 'illness' that is said to arise from biological 'malfunction' is a dominant framework for understanding mental distress (Allsopp et al., 2019; Read & Harper, 2020). The hegemony of the biomedical model can be conceptualised by Foucault's (1980) theory of knowledge and power being interlinked (Rose, 2023). Within an involuntary context, the biomedical model facilitates unequal power relations by elevating psychiatric knowledges which preclude a range of social, cultural, and spiritual explanations and responses to distress (Foucault, 1980; LeFrançois et al., 2013). As such, the idea of 'truth' is embedded in socio-political contexts, with 'facts' being produced through operations of power (Foucault, 1980). As conceptualised by the power-knowledge relationship, understandings and responses to mental distress outside of the dominant biomedical paradigm are often rendered untrustworthy knowledges (Foucault, 1980; Howe, 1994; Rose, 2023). For example, a study by Scanlan et al. (2020, p. 2) found that sixty-seven peer workers across NSW, experienced 'discrimination and isolation' due to 'pseudo-staff…[not] valu(ing) the contribution of peer work' and 'perceiving peer workers as "patients"' despite being hired as experts by experience. Critical mental health theorists challenge the 'invalidity' of alternative responses to distress, whereby what counts as evidence under the biomedical paradigm is narrowly defined (Cohen, 2017; LaFrance, 2007; LeFrançois et al., 2013). A singular medicalised narrative is problematic as it contributes to responsibilising discourse by locating distress as a deficit within the individual, rather than contextualising distress within a broader socio-political context (Morley & Stenhouse, 2021). A preoccupation with 'fixing' individuals to improve functioning, connects the biomedical model to neoliberalism (Lynch, 2017). Both neoliberal and biomedical paradigms share a focus on individual responsibility in contrast to addressing the social drivers of distress through social and community resources (Tseris, 2017b). An individualistic focus can undermine the role that wider societal and family supports of a person play in enhancing wellbeing. In Section 68 of *The Mental Health Act 2007* (NSW), it states that carers of persons scheduled under the Act are 'to be involved and to have information provided by them considered'. In NSW, *The Carers (Recognition) Act 2010* (NSW) also creates obligations for mental health facilities to 'recognise, include and support carers' of people experiencing mental distress (Carers NSW, n.d.; Thorburn, 2019). Despite such legislation, a study by Kokanović et al. (2017) found that families and other non-clinical support people felt distanced from care planning and experienced an unwillingness by professionals to meaningfully incorporate their expertise.

Research on the Use of Censorship in Involuntary Mental Health Treatment Settings

Censorship as a concept can be defined as 'an act of control, driven by a combustible mix of power, privilege, and fear' used to suppress the voices of marginalised groups 'to keep them marginalized' (Jaegar et al., 2023, p. 1). Within an involuntary mental health context, *The Mental Health Act 2007* (NSW) allows for censorship to occur by restricting people from voicing their experiences with the public, concealing the potential harms that are experienced (Miller, 2023). Doing so is justified based on the sanist notion of people experiencing mental distress as 'lacking insight' (Sims et al., 2021). This is a form of epistemic injustice, which Fricker (2007, p. 1) describes as when 'someone is wronged specifically in their capacity as a knower.' Epistemic injustice is characterised by exclusion and censorship and can occur in the form of testimonial injustice, whereby someone's word is devalued based on their marginalised identity, or hermeneutical injustice, which occurs when the way someone interprets their experiences is dismissed as it does not fit into the dominant frameworks of understanding. In involuntary contexts, the perceived legitimacy of the biomedical model can be leveraged as a grand narrative of human experience, which invalidates alternate explanations of distress as they do not fit into a rigid medical narrative (Tseris, 2022).

Research on the Relevance of a Gendered Lens

There is a gap in the literature in understanding how the intersection of gender and psychiatric oppressions may impact women within an involuntary mental health context (Ross, 2018). The lack of a gendered lens is problematic, as the impact of psychiatric biomedical explanations of distress may be experienced differently by women and therefore requires gender-sensitive responses (Soininen et al., 2013). The current medical-custodial response to mental distress is argued to mirror the power dynamics involved in gendered violence through coercive practices, such as masculine force used in restraint and the breach of consent (Moulding, 2015). Within such contexts, a lack of a gendered lens in trauma-informed policies fails to ensure the prevention of iatrogenic harm, which is the harm caused through treatment (Women's Health Victoria, 2019). Ussher (2011) conducted interviews with women who had experienced sexual violence, which revealed how the tactics of gendered harm were replicated in this cohort's encounters with psychiatry. The women in the study also explored how any anger that was expressed in the face of injustice was pathologized. Women have been historically constructed throughout psychiatric literature as being 'hysterical', 'insane', and driven by hormonal impulses when having displayed anger in the context of gender inequality (Breuer & Freud, 1956; Smith-Rosenberg, 1972; Ussher, 2011). Such labels were often given to women who possessed 'undesirable' traits that conflicted with femininity tropes (Chesler, 1972). This has transcended into current-day praxis through gendered bias in diagnoses, such as Borderline Personality Disorder (BPD) (Cohen, 2013). The Diagnostic and Statistical Manual of Mental Disorders (2013, p. 663) lists 'inappropriate, intense anger or difficulty controlling anger' as a key criterion for BPD. Ussher (2011) suggests that there is an unequal expectation placed on women to be passive, even in situations that warrant distress, with the diagnosis of BPD being overwhelmingly assigned to women who have experienced gendered violence. There is a small field of research, primarily from a feminist standpoint epistemology, exploring gender and psychiatry intersections (Ussher, 2011). My project seeks to contribute by actively interrogating structures of power embedded within psychiatric biomedical explanations of distress in involuntary mental health settings.

Methodology

This project is part of a larger study led by Dr Emma Tseris, and two survivor researchers (researchers with direct experiences of involuntary mental health treatment), exploring women's experiences of involuntary treatment in NSW from multiple perspectives (women with lived-experience, family and friends, and mental health workers). The purpose of the wider project is to develop improved understandings and responses to women's mental distress through Participatory Action Research (PAR). PAR utilises collaborative processes to centre people who have experienced injustice as agents of change (Fine et al., 2007; McTaggart, 1997). In this way, researchers work alongside rather than over the impacted individual or community to actively address the issue at hand (McIntyre, 2008). Semi-structured interviewing and action research groups using arts-based methods opened space for women from marginalised groups to participate in knowledge production (Huss & Bos, 2022). Women chose to disseminate the findings through a public website, academic scholarship, and a public exhibition. The public were invited into a social action led by women, that aimed to re-imagine mental health care for women. My honours project involved my attendance at the exhibition, and actively participating in the in-depth interviews by asking follow-up questions and clarifying intended meanings with the women.

Research question

The scope and purpose of my research project was to take a subset of the broader study, with the aim of understanding how women experience and resist psychiatric explanations of distress under involuntary mental health treatment in NSW. Within this paper, psychiatric explanations of distress refers to the dominant discourse of a person's diagnosis and the medicalised narrative which follows. The research question that guided my research was:

'How do women experience and negotiate psychiatric explanations of distress under involuntary mental health treatment in NSW?'

Theoretical Frameworks

A feminist theoretical underpinning aligns with this study's political pursuit of elevating women's voices from the margins. Whilst there is some divergence amongst the different strands of feminism(s), there is an overarching goal of ending the gendered oppression of women (Hooks, 2000; Phillips, 2015). Feminism(s) de-pathologizes women by situating distress within the context of gender inequality and considers a range of oppressive forces across diverse social locations (Butler, 1990; Phillips, 2015; Tseris et al., 2022). Crenshaw (1991) is often credited for coining the term 'intersectional feminism' which she described as 'a lens...for seeing the way in which various forms of inequality often operate together and exacerbate each other' (Steinmetz, 2020). This study applies an intersectional feminist lens, as women are often impacted by several oppressive structures (Karban, 2017).

In addition, critical mental health theorists suggest that the biomedical model can perpetuate inequality through an overemphasis on 'illness' being inherent to the individual as the sole narrative of distress (LeFrancois et al. 2013). Critical mental health theorists reframe distress as a response to structural inequities; suggesting that explanations are varied and can be social rather than purely biological. Feminist and critical mental health frameworks are highly compatible due to the shared goal of emancipating women from oppressive structures (Tseris et al., 2022).

Method and Data Collection

In alignment with both feminist and critical mental health frameworks, semi-structured, in-depth interviews were chosen as they provide a loose structure and allow for flexibility to discover new areas of significance identified by women (Dcruz & Jones, 2013). An interview guide was utilised to allow for consistency across the interviews. The interview guide produced by Dr Tseris in collaboration with survivor researchers, was in alignment with the theoretical standings. All interview questions were open-ended and allowed for women to answer (or decline) the questions in alignment with personal boundaries. The questions ended in phrases such as, 'only in as much detail as you would like to share' when exploring the potential harms that were experienced under involuntary treatment.

De-briefing was offered, rather than imposed. All women gave written permission for interviews to be recorded using an audio recording device, which were all professionally transcribed. Opportunity was given for women to look over the transcripts to promote transparency.

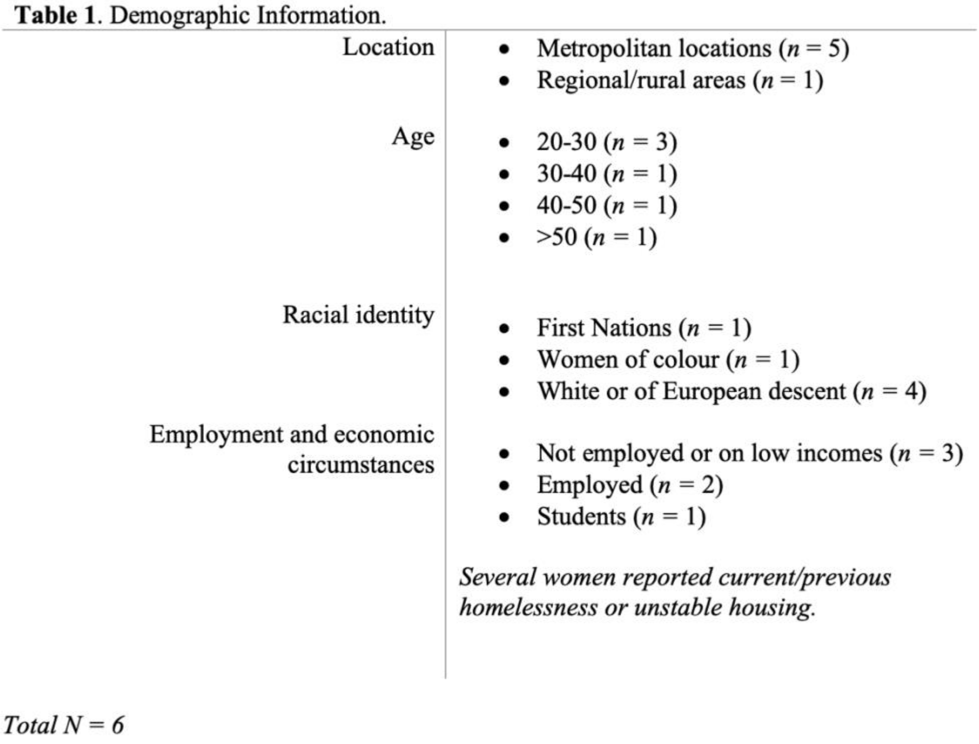
Participants

Six women with experience of involuntary mental health treatment in NSW were involved in my Honours project; four women participated in the interviews, and two women provided written descriptions that supported creative pieces from the exhibition. All six women within this study self-identified as cisgender women. Transcripts were de-identified for confidentiality reasons.

Ethics

Ethics approval was granted via the University Human Ethics Committee (project number 2022/173). A pre-interview discussion created transparency, particularly around the possible positives and negatives of participation. Written consent was gained freely, and it was reiterated that consent can be withdrawn at any time. Ethics was an iterative process that occurred at every stage of the research process by continuously considering how each decision could facilitate women’s agency.

Table 1. Demographic Information.



Location	Metropolitan locations (*n* = 5) Regional/rural areas (*n* = 1)
Age	20-30 (*n* = 3) 30-40 (*n* = 1) 40-50 (*n* = 1) >50 (*n* = 1)
Racial identity	First Nations (*n* = 1) Women of colour (*n* = 1) White or of European descent (*n* = 4)
Employment and economic circumstances	Not employed or on low incomes (*n* = 3) Employed (*n* = 2) Students (*n* = 1) *Several women reported current/previous homelessness or unstable housing.*

Total N = 6

Data Analysis

Braun and Clarke’s (2012) thematic analysis, which provides a method for analysing themes across a data set, was chosen for its flexibility and adaptability. The process of analysing the data was continuous and iterative and began during the interviews, where researchers would reflect upon key concepts that arose from women’s stories and clarify the intended meanings with the women. The theoretical frameworks of feminism and critical mental health theory guided the analysis, which centred power and gender and survivorship and resistance. An intersectional feminist lens also allowed for a range of power relations to be explored.

The data was coded manually, which involved reading and annotating both the transcripts and the written descriptions that supported the creative pieces using the same thematic analysis. In alignment with an inductive approach, there were no predetermined codes, and therefore the analysis was driven by what was in the data. Initial codes were identified by taking short phrases or words that were articulated by women from the interviews and written descriptions that supported the artworks. Twenty-one codes were manually sorted into potential sub-themes and themes using mind maps. Eleven sub-themes were ultimately incorporated into four larger themes and included based on whether they reflected concepts that were present across the data set. For example, the subtheme 'emotional impact of seclusion' was discarded as it was mentioned by one woman, whereas the subtheme 'emotional impact of coercion' was included under the theme 'censorship of emotion' for its coverage across the data set. Ongoing consultation between researchers allowed for discussion around potential themes, which were then discarded if they did not closely answer the research question. Three themes were finalised, with two themes being supported by data from across all transcripts and written descriptions that supported the artworks, and one theme being supported by all transcripts and one written description.

Findings

All women involved in this study described involuntary mental health treatment as a profoundly harmful experience which produced ongoing implications. Women described the ways in which psychiatric and gender oppressions intersected to perpetuate the silencing of women. Collectively and individually, all women displayed acts of resistance towards psychiatric and patriarchal hegemony. Three major themes were identified in the analytical process: The Censorship of Knowledge; The Censorship of Emotions; and The Censorship of Acts of Resistance.

The Censorship of Knowledge

Several women identified having a female identity and experiences of gendered violence as targets for receiving the diagnosis of Borderline Personality Disorder (BPD). Being labelled with this highly stigmatised diagnosis was described to have implications that spanned over many years, including facing discrimination from mental health professionals both during and post admission. Three women believed that being labelled with BPD was a way for mental health professionals to discredit women's experiences. By avoiding listening to women's stories, the opportunity to provide a holistic response that addressed the social drivers of distress was lost:

'I've had this fear that I might be diagnosed with borderline personality disorder…because of the way, woman in particular, are treated in the hospital with that diagnosis…it's a terrible way of framing trauma… you just have crocodile tears… you're manipulative…all these bad things [rather than] what made you so frightened that you burst into tears.'

As women either experienced or witnessed the negative impact of labelling, all women involved in this study described complex strategies to be perceived as 'compliant'. Women adapted to prescribed norms as any behaviours outside this were distorted as evidence of 'illness'. Several women described the strategic management of emotions to avoid being labelled with BPD:

'…the more I presented as difficult… that would land me with a borderline personality diagnosis, I had to temper things down…not get too frustrated… the idea that [mental health professionals] could discount what I thought were valid kind of voicings, I thought it was much more likely if I had that diagnosis.'

For the women involved in this study who were labelled with a psychiatric diagnosis, such as BPD, it was described how any knowledge that was provided was automatically rendered untrustworthy by mental health professionals. Furthermore, it was explored how a master psychiatric narrative also disqualified any alternate knowledges that moved beyond the constrains of diagnostic categories. One woman who identified as a university student of an Indian heritage explored this idea through poetry, read to us in the interview, to creatively critique how psychiatry tried to systematise complex experiences due to an inability to sit with ambiguity:

'My mind flows like water, shapeless in my hands, they know it is beyond their reach beyond what they understand. They think with all these guidelines my mind can be measured. Their fragile certainty is the madness in their methods.'

This was also reflected by one woman who challenged the deterministic biomedical paradigm by describing the discrepancies in the explanations that were provided by psychiatry, heightening the irony of alternate knowledges being invalidated for a lack of certainty:

‘Everyone can have such different opinions of what’s going on for you, and you’re at their mercy, you’re just thrown around while it’s all happening… that’s why I don’t trust doctors… [like] gods.’

Not only was the knowledge that women provided rendered untrustworthy, but also the way women made sense of such experiences were invalidated. Several women described how personal processes of meaning-making were quashed by medicalised explanations and standardised documentation processes that failed to explore the whole person. A First Nations woman, who sat at the intersection of colonial and psychiatric oppressions, creatively described the absence of ways of knowing, being, and doing that honour holistic responses to social emotional wellbeing outside of western biomedical frameworks:

‘Mental health services often focus on words and creating new documents, coming from a white perspective. This photo is about the things that are important and have made a difference for me, including community and connection to Country.’

The Censorship of Emotions

With displays of emotion being seen by mental health professionals as an indicator of being an untrustworthy knowledge provider, women described how the forced administration of psychotropic medications was used excessively to suppress emotion. An overreliance on medication had detrimental effects on women’s quality of life, with gendered implications such as sedative side-effects impacting on mothering responsibilities. Medication was often given without explanation of the side-effects, and accompanied by excessive force when injected involuntarily, which was described as ‘*highly traumatic*’:

‘I remember very clearly saying, ‘Well, that makes me feel angry.’ Next thing you know, I’ve got five bloody people on top of me and I’m being injected with something…I woke up three days later. It was one of the worst experiences of my life.’

The binary thinking behind ‘too much’ emotion needing to be eliminated until the point no emotion is felt at all, as well as being pathologized for not being ‘emotional enough’, or in the ‘right’ ways, was described by two women as having long-term implications such as a loss of identity, with one woman stating:

‘If you remove every part of me, of what makes me me, yeah, you'd get rid of the ‘disease’, but what about the rest? What about who I am, what I can accomplish in life? All that's been removed.’

Furthermore, several women described how the system is coercive around how women are ‘supposed’ to feel in the world despite oppression. All four women who were involved in the interviews described adverse social circumstances, such as gendered violence, as having been the drivers of distress. However, the meaning behind distress was lost through the biomedical approach that equates emotions with pathology rather than social meaning. One older woman who self-identified as a lesbian from regional NSW, described a situation where professionals from across systems ignored the social and responsibilised women for the violence that was experienced:

‘A couple of women that I was in [involuntary treatment] with had been experiencing domestic violence, and when the police had come, they’d been taken, not looking at what had happened. It’s like they were hysterical …and so the problem was, again, located within them.’

The Censorship of Acts of Resistance

Despite attempts by mental health professionals to eliminate women’s knowledges and emotions, all women involved in this study demonstrated everyday acts of resistance against psychiatric and patriarchal control to regain, what one woman described as, the ‘*power and freedom that comes from expanding beyond the confines of their stigma and abuse.*’ One woman involved in this study, expressed an innate desire to become a mother, however described being inundated with paternalistic messaging by mental health professionals about the ‘wrongness’ of wanting to be a mother when labelled as ‘mentally ill’. The woman’s knowledge of herself and her goals were framed by mental health professionals as being unachievable as mental distress was conflated with inadequate mothering. Whilst reproductive control was resisted, it was predicted how psychiatry would try to reframe becoming pregnant in a deficit manner:

'The message I got was, you shouldn't be trying to have kids ... I keep wanting to bump into my old psych ... see me with my big [pregnant] belly now. But he'll probably just think it's meds.'

Due to a lack of understanding from clinical spaces, women attempted to gain support from family networks and wider societal supports, including peer-support groups. Several women discussed experiences of psychiatry attempting to breakdown the ethos of the lived experience community by censoring the benefits that come from mutual understanding. However, all women were able to counteract this through alternatives to recovery outside of the confines of a medical-custodial response to distress, including gaining support from peer-led spaces:

'Being in a group of people ... who feel the same things, who have experienced many of the things I have. Looking at how they're dealing with it, and how I'm dealing with it helps.'

The sense of community that was fostered by this project was viewed as a source of power by women. All women described how being co-generators of knowledge in this project was an act of truth-telling, by revealing the overwhelmingly adverse experiences which were censored from the public:

'This project has been an absolutely uplifting experience because it's shedding light on something that is often a dirty secret, it's often something that is argued that doesn't exist.'

Both collectively and individually, women were able to resist the '*the oppressive and dehumanising role psychiatry has made for [women]*', and spoke of reclaiming an identity outside the confines of the diagnostic labels that censored '*many hopes and dreams'*:

'I want you to know that my diagnosis doesn't define me… This is my life. It is my mind, my body, and it belongs to me. And with that there is hope.'

Discussion

This study aligns with the literature by revealing how involuntary mental health settings can reflect and heighten gender oppressions (Tseris et al., 2022; Quiros & Berger, 2015). Based on the experiences of women in this study, it appears that censorship has the potential to be used by psychiatry as a powerful strategy to conceal women's knowledges, emotions, and acts of resistance as a means of maintaining control by perpetuating the silencing of women. Women who sit at the nexus of gender and psychiatric oppressions, are susceptible to experiencing iatrogenic harm (Watson et al., 2020). This poses implications for social work, including urgent changes to practice, as well as systems changes that provide alternative responses to distress beyond the confines of a medical-custodial approach.

The findings of this study align with other research that established how involuntary mental health treatment often leads to the amplification rather than alleviation of distress (Fullagar et al., 2019; Tseris, 2017a; Ussher, 2011). However, this study delved even deeper by applying an intersectional feminist lens, which rendered visible the gender-specific harms experienced by women under involuntary treatment. For example, women described experiences of psychiatry exercising reproductive control; gender-bias in diagnoses; the pathologisation of women's emotions; and professionals being unresponsive to gender-based violence. Applying an intersectional feminist lens also elucidates the impact of involuntary treatment for women who are at the intersection of multiple layers of oppression, such as poverty and racism. For example, a First Nations woman recognised how processes of meaning making outside of westernised biomedical understandings of distress were delegitimatized. This is in alignment with the literature on epistemic injustice, as perspectives are dismissed or seen as evidence of pathology (Fricker, 2007).

Furthermore, women involved in this study described the egregious impact of the medicalisation of women's distress through an overreliance on the biomedical model that links emotion to 'illness' rather than social meaning. Despite research connecting distress to poor social determinants of health, psychiatric explanations of distress continue to focus on narrow forms of evidence, which preclude social explanations (Allsopp et al., 2019; Marmot, 2017; Read & Harper, 2020). This study aligns with Foucault's (1980) conceptualisation of knowledge and power being interlinked, as psychiatric explanations of distress are given pre-eminence in involuntary mental health settings, leveraging off the binary of 'valid' and 'invalid' knowledges to exercise power (Rose, 2023). The findings of this study highlighted the dehumanising effects of reducing women to a diagnostic label. Women described the enduring impact of being denied agency through psychiatric labels, such as a loss of identity. Moreover, being labelled with gendered diagnoses, such as BPD, led to highly discriminatory behaviours by mental health professionals, including the discrediting of women's experiences. This is particularly concerning as the literature suggests a link between experiences of gendered violence, and diagnoses such as BPD; suggesting that the core drivers of distress are often concealed rather than addressed (Ussher, 2011). This conflicts with the rhetoric of trauma-informed care that aims to consider a person's history to provide a holistic response (Levenson, 2017). As such, the disconnect between what services claim to be doing, and what had *actually* been experienced under involuntary treatment by women in this study, highlights how the current popularisation of 'trauma-informed care' is insufficient in ensuring women do not experience iatrogenic harm. Women involved in this study described how the mental health system can replicate the tactics of gendered harm through force that is exerted through physical and medical restraint; a lack of respect for ones' consent; and the responsibilisation of the violence that had been experienced.

All women involved in this study subverted the stereotype of being a passive victim, by having displayed various acts of resistance to psychiatric hegemony. This included the strategic management of emotions to avoid stigmatised diagnoses; creativity as a way of breaking away from rigid frameworks; refusing to succumb to paternalistic messaging surrounding mothering; connecting to Country as a source of healing; gaining support from peer-led spaces; reclaiming identity outside of a diagnosis; and involvement in this project as a way of truth-telling. However, women explored how mental health services attempted to censor women's resistances to maintain the status quo. For example, it was described how mental health services did not make space for women's knowledges and ways of understanding distress. This is incongruent with critical mental health and feminist frameworks that argue that the expert on a woman's life is the woman herself. In this way, elevating lived experience knowledges and peer-led spaces contributes to a larger emancipatory movement that sees a critique of the professional-client hierarchy (Cohen, 2017). Women explored alternatives to addressing mental distress outside of the confines of coercive treatment. This challenges the binary notion that neglect is the only alternative to coercion, which is sometimes used to justify the 'inevitability' of coercive practices. As such, the findings of this study heighten the importance of offering alternatives in the plural form to ensure one rigid 'truth' is not replaced with another.

The Role of Social Work

The social work profession has been largely complacent with the need for involuntary mental health treatment; attempting to reconcile social work values through practice changes from within rather than an outright rejection (Maylea, 2017). Participating in coercive practice is highly incompatible with recovery-orientated and trauma-informed responses to mental distress, requiring an urgent paradigm shift that moves towards anti-carceral responses that are founded on human rights and social justice. Such responses may include recognising the value of wider family and societal networks by meaningfully incorporating their expertise in decision-making and care planning for a holistic response. Doing so has been shown to decrease reliance on acute settings and improve overall wellbeing outside of the constraints of involuntary treatment (Kokanović et al., 2017; Thorburn, 2019). Social workers can also play a role in building a stronger alliance with survivors of involuntary mental health treatment by advocating for lived experience expertise to be reflected through policy, practice, and research. This will allow for a redistribution of power by providing alternate understandings and responses to mental distress outside of the biomedical paradigm from people who have themselves experienced the impact of diagnosis (Probert, 2021). Other responses can permeate around addressing the poor social determinants of health that occur within the context of gender inequality and contribute to mental distress, such as gendered violence, by advocating for resources and supports (Karban, 2017). For example, stronger interagency liaison between social workers and housing providers may be beneficial in assisting women who are experiencing gendered violence to secure safe and affordable housing. On a policy level, social workers must advocate for updating trauma-informed guidelines to include a gendered-lens and therefore 'recognize gender equality as a basic principle in the provision of mental health services' (WHO & UN, 2023, p. 81). There is an urgent need for social work to advocate for the amendment of mental health legislation to look at ways of providing other kinds of support and resources to women so that coercive 'care' is much less relied upon as a response. This is necessary in preventing gendered harms, which may include overt coercive practices such as restraint but also covert forms of coercion such as a loss of agency, silencing, and pathologising, which were also components of the gendered oppressions experienced by women in this study. Through the synthesis of critical mental health and feminist movements, which share the goal of emancipating women from oppressive structures, there is potential to provide socially just responses for women experiencing distress beyond a medical-custodial approach. In this way, social work plays a role in extending the feminist goal of ending violence against women to the realm of involuntary treatment, as a context where women may experience gendered harm (Tseris et al., 2022).

Conclusion

This study has revealed the impact of involuntary mental health treatment on women who sit at the nexus of sanist and sexist discourses. The women in this study all experienced and negotiated psychiatric explanations of distress under involuntary mental health treatment in NSW as a form of censorship, specifically the censorship of knowledge, emotions, and acts of resistance. The findings suggest that a master psychiatric narrative of human suffering censors the alternate ways of producing and interpreting knowledge. Psychiatric explanations of distress were revealed to dictate how women are 'supposed' to feel, despite being impacted by several oppressive structures. This hinders opportunity to unpack the meaning behind distress within the broader context of gender inequality. Despite describing experiences of psychiatry attempting to nullify acts of resistance, alternative supports outside the confines of involuntary treatment continued to be explored by women.

Strengths and Limitations

It is important to acknowledge that this project has several limitations. With the project being constrained by a small word count, it is limited by focusing on text-based data. A visual analysis of the artworks that were displayed at the exhibition was excluded to avoid a superficial analysis. In all interviews, women's creative pieces were discussed, and two accompanying written descriptions were included in the data analysis to mitigate the absence of the visual. This project is also limited by a small sample size, and therefore the findings of this study do not offer a representation at a population level. However, a small sample size allowed for greater depth when analysing the transcripts and written descriptions that accompanied the creative pieces, avoiding individual voices being lost through large amounts of data. Being part of a wider project, my project solely focused on women's experiences, excluding an analysis of the perspectives of family and friends. Despite such limitations, the urgent need for a paradigm shift in the way women's distress is responded to is strongly conveyed through this study, including acknowledging the value of wider societal supports. The study's major strengths lie in its capacity to actively challenge epistemic injustice by centring women's voices and building up alternatives based on women's knowledges through creativity and dialogue.

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