

**Tseris, E., Hart, E. B., & Franks, S. (2024). *Psychiatric Oppression in Women's Lives: Creative Resistance and Collective Dissent*. Palgrave Macmillan Cham, 228 pages, ISBN 978-3-031-65067-3**

**Reviewed by Sarah Morrison\***

Emma Tseris, Scarlett Franks, and Eva Bright Hart's *Psychiatric oppression in women's lives: Creative resistance and collective dissent* is a searing contribution to the growing field of critical mental health scholarship. Grounded in feminist, intersectional, and survivor-led approaches, this book intervenes at a moment of heightened scrutiny around mental health care systems. It emphasises an often overlooked form of gendered violence: the pathologisation and oppression of women by psychiatry. The authors draw on a multi-stage Participatory Action Research (PAR) project, including interviews with 40 women in New South Wales, I-Poems, collective conversation workshops, and art-making. This methodological approach centres survivors as co-researchers, resisting the epistemic injustices embedded in traditional, clinician-led research. The book's intellectual rigour is therefore matched by its ethical commitment to privileging lived experience over clinical authority.

All three authors bring complementary areas of expertise to this work. Tseris is a senior lecturer in Social Work at the University of Sydney, with a strong background in feminist and critical mental health research. Franks and Bright Hart are survivor researchers, and Bright Hart is a social worker and public health professional. Their diverse academic and practical backgrounds guide their epistemologies as they critique dominant psychiatric paradigms and make space for radically alternative ways of understanding and responding to mental distress.

The key contribution of the book lies in its analysis of psychiatry as a gendered system of social control. Challenging the assumption that psychiatry is primarily therapeutic, the authors draw on Bonnie Burstow's (2014) critique of psychiatry as an institution of social control to expose its carceral functions, particularly the coercive nature of involuntary treatment and risk assessment regimes. Clinical language, they argue, obfuscates the inherently coercive nature of many interventions, and in doing so, enshrines a benevolent image of the psychiatric institution. The book situates these practices within broader patterns of patriarchal regulation, showing how women who resist dominant social norms are especially vulnerable to psychiatric intervention. Interview accounts with women who have experienced involuntary psychiatric treatment reveal psychiatry as a gendered mechanism of control and illustrate how psychiatric labels are wielded to undermine women's credibility and autonomy. One woman reflects, "diagnostic language steals my language and my ability to define my experiences in a meaningful human way" (p. 64).

The authors further demonstrate how psychiatric discourse operates as a tool of social control by shaping assumptions about mental health care. They offer a pointed critique of both 'trauma-informed care' and the pervasive rhetoric of 'crisis' in contemporary mental health policy. This 'crisis' is reinforced through

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common reporting and global health discourse; for example, the World Health Organization (WHO) (2022) notes that mental disorders account for one in every six years lived with disability and epidemiological studies demonstrate that more than a quarter of all men and women in the European Union will have symptoms of at least one psychiatric disorder in the course of just one year (Wittchen & Jacobi, 2005). Building on Rose's (2023) analysis, the authors show how the invocation of crisis depoliticises debate, narrowing reformist agendas to service improvement while diverting attention from structural harm. In this framing, 'crisis' is mobilised without critical interrogation of what constitutes disorder, ultimately advancing calls for expanded treatment rather than engaging in the socio-cultural and political analyses necessary to address the systemic conditions that produce distress.

The authors demonstrate how this same pattern of depoliticisation can be seen in the trajectory of trauma-informed care. Initially conceived as a radical shift away from individualising pathology, it has been diluted into a framework that deflects attention from structural and systemic drivers of harm, and in doing so, obscures "the iatrogenic harms that occur during encounters with the mental health system" (p. 22). Likewise, the authors challenge the assumption that psychotherapy necessarily offers a progressive alternative to biomedical psychiatry. They demonstrate how mainstream therapeutic approaches can reproduce neoliberal logics, locating distress within the individual, prescribing adaptation and compliance, and ultimately reinforcing the very systems they purport to resist.

Here, the book's feminist perspective is vital, as such harms are not experienced evenly, but are intensified for women whose expressions of distress are already subject to gendered scrutiny. For example, approximately 75% of individuals diagnosed with Borderline Personality Disorder (BPD) are women (American Psychiatric Association, 2022). This overrepresentation is closely tied to histories of sexual and interpersonal violence, as women with BPD diagnoses are disproportionately likely to have experienced childhood sexual abuse (Ussher, 2011). Such diagnostic patterns reflect a long-standing psychiatric tendency to depoliticise sexual abuse by reframing the lasting effects of trauma as evidence of personality pathology rather than as understandable responses to violence (Caplan, 1995; Cohen, 2016).

Within ostensibly trauma-informed systems these dynamics can persist. Acknowledgement of a woman's traumatic history may coexist with coercive treatment, surveillance, and ongoing psychiatric labelling that pathologise her survival strategies. Rather than fostering safety, trauma-informed rhetoric can be weaponised to manage and contain women deemed difficult or non-compliant, reinforcing the very systems of control it claims to resist. This gendered dynamic is further illustrated by Luhrmann's (2000) ethnographic study, which found that psychiatrists often described the "typical" BPD patient as "an angry, difficult woman—almost always a woman—given to intense, unstable relationships and a tendency to make suicide attempts as a call for help" (Luhrmann, 2000, p. 113). Luhrmann (2000, p. 115) notes that such views bear striking similarity to nineteenth-century psychiatric attitudes toward 'hysterics', revealing an enduring professional revulsion toward those labelled with a personality disorder.

The authors also challenge the assumption that psychotherapy necessarily offers a progressive alternative to biomedical psychiatry. They demonstrate how mainstream therapeutic approaches can reproduce neoliberal logics, locating distress within the individual, prescribing adaptation and compliance, and ultimately reinforcing the very systems they purport to resist, systems that have historically pathologised women's emotional lives and survival strategies.

The inclusion of family members and mental health workers in the PAR process adds significant nuance to the book's analysis of systemic power. Alongside interviews with women survivors, the authors conducted interviews with family members and mental health professionals, and facilitated eight collective workshops with mental health workers, many of whom felt marginalised within their own institutions. These perspectives reveal the complex interplay of complicity, constraint, and distress that permeates the mental health system. Family members frequently reported feeling excluded from decision-making by professionals, while simultaneously being drawn into coercive processes over which they had little control.

Mental health workers, meanwhile, described profound moral distress as they navigated tensions between their professional responsibilities and their personal ethics. One social worker spoke of “feeling like you don’t have any power as a social worker in a hospital system” (p. 200) while others recounted being dismissed in supervision, told they were “too emotional” (p. 201) or warned that expressing distress would make them appear “incompetent or not suited to the work” (p. 200). These dynamics foster a climate of fear, of ridicule, pathologisation, reputational damage, and even job loss. The authors clearly highlight the parallel forces of oppression operating within the system; however, they do not fully explore the gendered dimension of worker oppression. The “too emotional” framing draws directly on entrenched stereotypes that undermine women’s authority in the workplace, a pattern that is particularly stark in caring professions such as social work, where women comprise 84% of the workforce in Australia (Long et al., 2025). This omission is notable given the book’s explicit focus on women’s lives.

By including mental health workers accounts, the authors resist reductive portrayals of psychiatric power as a simple binary between oppressors and victims. Rather than demonising individual actors, they demonstrate how systemic structures constrain not only service users but also those tasked with providing care. This nuanced framing reinforces the book’s central argument that meaningful change cannot be achieved through piecemeal reform alone; it requires a radical reimagining of mental health systems themselves.

While the authors situate the perspectives of family members and mental health workers within a broader critique of systemic power, their analysis stops short of connecting these dynamics to the structural imperatives of capitalism. Like all institutions under capitalism, the mental health system is organised along class lines, with a small minority shaping policy and a much larger workforce tasked with implementing it, often under conditions that compromise their own ethics and wellbeing (Burstow, 2015). The authors effectively challenge the framing of psychiatric survivors and mental health workers as opposing groups, highlighting how many workers are themselves depressed, constrained, and oppressed by the very profession they inhabit. This shared experience of alienation reflects a deeper truth; all labour under capitalism ultimately serves to reproduce a system that prioritises profit and control over human need. Psychiatry’s coercive and disciplinary functions cannot be disentangled from the economic and political order that sustains them; dismantling psychiatric oppression in any meaningful way requires confronting, and ultimately abolishing, the system that demands it (Cohen, 2016).

Another major contribution of the book lies in its shift from critique to possibility, foregrounding the diverse ways women resist and subvert psychiatric violence. In challenging the clinical archetype of the non-compliant patient, the authors reframe resistance as a form of feminist political agency. This resistance spans a spectrum from overt acts of refusal and activist organising to the quieter but no less political practices of everyday self-preservation. Drawing on Audre Lorde’s (1988) framing of self-care as self-preservation, the authors position creativity, rest, and community-building not as apolitical coping strategies but as deliberate acts of feminist resistance. A particularly compelling example of creative resistance is the art exhibition ‘*Unscheduled*’, which emerged from the book’s PAR process. Conceived and curated collaboratively with survivor participants, the exhibition brought together paintings, photographs, poetry, sculpture, and textile works that embodied lived experiences of psychiatric oppression and survival. The exhibition’s title alludes to both the unpredictability of mental distress and the rejection of institutional timelines and treatment schedules imposed by psychiatric systems. By locating these works in a public space, the project disrupted the privatisation of distress and challenged the containment of survivor narratives within medical records or clinical encounters. As the authors observe, “art brought transformative potential because it expanded thinking and possibilities outside the parameters of medical discourses, and beyond ‘rational’ and ‘cognitive’ engagement with human experiences in mental health systems” (p. 142). Through collective art-making, participants were able to respond directly to the institutions that had silenced them,

transforming personal narratives into embodied political critique. In this framing, art is not merely a therapeutic outlet, but “a radical act of response and resistance” (p. 142).

The book concludes with both a call to action and a vision for transformation. The authors argue for moving beyond individualised, pathologising models of distress toward frameworks that recognise the socio-political conditions from which suffering emerges. They critique the dominant orientation of mental health awareness campaigns, which frequently focus on reducing stigma while leaving the structural drivers of harm untouched. Rather than prescribing a single alternative, they advocate for pluralistic, community-led approaches—peer support networks, grassroots organising, and decolonial models that honour diverse understandings of distress. By grounding these possibilities within the framework of collective dissent, the authors situate their work as part of a broader struggle for justice and liberation in mental health.

Methodologically, *Psychiatric oppression in women's lives* is a valuable resource for researchers committed to centring lived experience in politically engaged ways. Its integration of feminist analysis, creative methods, and survivor-led epistemologies makes it particularly relevant for critical mental health scholars, sociologists, health practitioners, and policy-makers seeking to challenge normative psychiatric frameworks. The authors' transparent account of navigating institutional ethics within an oppressive system provides rare and practical insight for those attempting to disrupt biomedical dominance in their own research practice. Crucially, the authors do not shy away from the ethical tensions that arise when conducting research within systems whose institutional ethics processes remain tethered to biomedical assumptions. Their reflections reveal the complexities of stepping outside dominant paradigms while still navigating their procedural and political constraints. This candid engagement elevates the book beyond a case study of psychiatric oppression, positioning it as a methodological guide for developing politically grounded, relational, and ethically responsive approaches, particularly in contexts where participant voices are routinely marginalised or co-opted.

While *Psychiatric oppression in women's lives* centres on empirical case studies from Australia, its critique of psychiatric coercion resonates powerfully within the Aotearoa context. The structural logics underpinning mental health care across both settler-colonial states are shaped by shared histories of colonisation, patriarchal governance, and the regulation of Indigenous and female bodies. In each setting, psychiatry has historically operated as a mechanism of social control, particularly for those who resist or fail to conform to dominant norms of gendered and racialised citizenship. As Tseris et al. argue, “the psychiatric system reproduces and exacerbates colonial harm and intergenerational trauma through a carceral response” (p. 18). In Aotearoa, these dynamics are starkly visible in the operation of the Mental Health (Compulsory Assessment and Treatment) Act 1992, long criticised for its disproportionate and racialised impacts (Ministry of Health, 2023). As of 2022, Māori were four times more likely than non-Māori and non-Pacific people to be subjected to community treatment orders, and 3.6 times more likely to be placed under inpatient treatment orders (Mental Health Foundation, 2024). That same year, clinicians made 6,097 applications for compulsory treatment orders, 88% of which were approved by the courts (Ministry of Health, 2023). Such figures cannot be disentangled from the enduring colonial architectures of Aotearoa's mental health system, in which psychiatric institutions continue to function as technologies of containment, surveillance, and assimilation (Durie, 1994). Women, particularly wāhine Māori, remain overrepresented among those who are involuntarily treated, an outcome not simply of diagnostic bias but of intersecting oppressions shaped by gender, race, colonisation, and economic marginalisation (Beaglehole et al., 2024). As Crenshaw (2013) argued, systems of power cannot be understood in isolation; they converge in ways that produce uniquely patterned exclusions and harms.

Furthermore, the critique of trauma-informed care employed by Tseris et al. (2024) rings true to efforts to integrate Māori models of health. While such models are often adopted under the banner of ‘culturally competent care’, their incorporation has frequently been superficial, layered onto existing services without challenging the Eurocentric logics embedded in mental health law and institutional practice. As the

Mental Health Foundation (2024) has noted, the continued reliance on coercion within psychiatric care is fundamentally incompatible with culturally grounded and rights-based approaches. The foundations call for the absolute minimisation of compulsory treatment aligns with the critical interventions offered by Tseris, Franks and Hart, who advocate for the development of alternative frameworks rooted in relational, collective, and emancipatory ethics.

*Psychiatric oppression in women's lives* is a compelling and necessary work that challenges psychiatry's carceral logics, centres survivor knowledge, weaves together collaborative research and visions for collective liberation, and insists on the political nature of both distress and healing. In doing so, the book's analysis reinforces the broader feminist and Marxist insight that psychiatric oppression cannot be dismantled in isolation from the intersecting systems of colonialism, patriarchy, and capitalism that sustain it. This book should be read widely by those committed to dismantling systems of psychiatric oppression and building care systems that empower rather than contain.

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