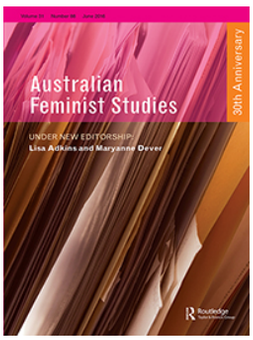

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Gender, Disability Rights and Violence Against Medical Bodies

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ABSTRACT

We take as our point of intervention one category of violence which sits outside the forms of violence against women which are both currently prohibited by criminal law and the focus of violence against women campaigns: non-consensual medical interventions (or, as we refer to it, 'lawful medical violence'). By drawing on critical disability studies, particularly feminist disability theory, we argue that lawful medical violence has been rendered socially and legally permissible because of the medicalisation of disabled women's bodies and the related pathologisation of their behaviour and life circumstances. These processes sit at the intersection of gender and disability, drawing on gendered social norms of ability and sexuality to construct women with disability as genderless and dehumanised, and in turn depoliticising non-consensual medical interventions in these women's bodies by reconstituting them as therapeutic and benevolent. In order to recognise and contest lawful medical violence as violence against women, mainstream feminist scholars and activists might consider turning to different legal, institutional and spatial sites of violence and challenging deeply embedded divisions and foundational concepts in law related to mental capacity.

In this article we focus on one category of violence which sits outside the forms of violence against women which are both currently prohibited by criminal law and the focus of violence against women campaigns: medical interventions committed exclusively or disproportionately on persons with disability without their consent ('non-consensual medical interventions') or, as we refer to it, 'lawful medical violence'. By drawing on critical disability studies, particularly feminist disability theory, we argue that lawful medical violence has been socially and legally permissible because of the medicalisation of disabled women's bodies and the related pathologisation of their behaviour and life circumstances. These processes sit at the intersection of gender and disability, drawing on gendered social norms of ability and sexuality to construct women with disability as genderless and dehumanised and in turn depoliticising non-consensual medical interventions in these women's bodies by reconstituting them as therapeutic and benevolent. In order to recognise and contest lawful medical violence as violence against women, in what follows we argue that mainstream feminist scholars and activists might consider turning to different legal, institutional and spatial sites of violence and challenging deeply embedded divisions

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and foundational concepts in law related to mental capacity. In particular, we highlight recent developments in international human rights in relation to disability, developments which involve shifts from protecting people with disability through acts authorised by third parties to a realisation of the vulnerability generated by the very denial of autonomy entailed in removing legal capacity and via acts that others authorise in the gap created by this removal of legal capacity. These shifts, we suggest, provide new possibilities for framing non-consensual medical interventions as violence against women with disability.

While national statistics specifically on violence against women with disability are limited (this itself being a significant issue [Cadwallader, Kavanagh, and Robinson 2015; Dowse et al. 2016]), available data indicates that women with disability experience disproportionate rates of violence (particularly sexual violence) when compared to men with disability and to women and men without disability (Dowse et al. 2016; Frohmader and Sands 2015, 38; in an international context see Hughes et al. 2012). Moreover, certain groups of women with disability, such as women offenders with disability, are more vulnerable to violence than other women with disability (Baldry, Dowse, and Clarence 2012). Violence against women with disability takes many forms including:

> physical, sexual, psychological and economic violence and abuse as well as institutional violence, chemical restraint, forced or coerced sterilisation, forced contraception, forced or coerced psychiatric interventions, forced abortion, medical exploitation, withholding of or forced medication, violations of privacy, forced isolation, seclusion and restraint, deprivation of liberty, denial of provision of essential care, humiliation, and harassment. (Frohmader, Dowse, and Didi 2015, 14)

Appreciating the full breadth and complexity of the forms of violence experienced by women with disabilities, notably the 'unique' forms it takes, requires two preliminary moves. The first is to step outside of the boundaries of and ordering of violence by criminal law. Austin Sarat and Thomas R Kearns argue that law holds a monopoly over what forms of violence are considered legitimate acts of force (Sarat and Kearns 1992, 4; in the specific context of gender and legal violence see Hunter 2006; and disability, gender and legal violence see Steele 2014). Physical force *becomes* violence through being identified as a criminal offence. This approach of stepping outside of criminal law's boundaries of and ordering of violence opens up the possibility of recognising as violence acts of force which are presently *permitted* by law, and this then turns critical attention to law's complicity in this violence. So, additional to forms of violence which are unlawful, there are also forms of violence against women with disability which are *lawful*. These include non-consensual interventions in the bodies of women with disability such as in the context of restrictive practices in educational or healthcare settings, removal of life sustaining treatment and medical treatment. These forms of violence are lawful and are *not* prohibited by criminal law (e.g. through the offence of assault) because even though the woman herself has not consented to the physical contact with and intervention in her body, law recognises the authority of a third party to consent to the intervention (e.g. through guardianship law), the intervention is pursuant to a legislative framework which lawfully authorises detention or treatment and renders consent (individual or third party) unnecessary (e.g. forensic and civil mental health laws) or the intervention occurs in the context of responding to an 'emergency' and is justified pursuant to the defence of necessity.

The second preliminary move is to attend to the affective dimension of violence against women with disability: not only what is done to women, but how we (as individuals, a community and a legal system) are conditioned to fail to recognise this as an injustice and to respond accordingly. Central here is the lack of social and legal recognition of much violence against women with disability. Speaking of violence against people with disability more broadly, Carolyn Frohmader and Therese Sands argue that violence against people with disability has been largely 'detoxified' and more readily seen as something less than a crime (e.g. a workplace issue, an administrative complaint) or even beneficial to the individual (e.g. as necessary medical treatment or behavioural discipline) (Frohmader and Sands 2015, 19).

Our focus in this article is on one form of lawful violence against women with disability – medical interventions committed exclusively or disproportionately on women with disability without their consent ('non-consensual medical interventions') – which we term 'lawful medical violence' (Steele 2014). Lawful medical violence includes sterilisation, involuntary mental health treatment, involuntary detention in mental health facilities, forms of chemical restraint such as the use of mood stabilisers and psychotropic drugs in institutional residential settings such as aged care facilities and group homes. Lawful medical violence is a disabled phenomenon because it involves interventions related to treating or mitigating disability itself or its behavioural, physical or emotional effects and risks. For this reason, lawful medical violence in the context of this article does not extend to procedures which are not associated with disability such as blood transfusions or appendectomies. Lawful medical violence is also a disabled phenomenon because it occurs in legal circumstances structured around mental incapacity and hence is legally impossible in relation to people without disability who are deemed to possess mental capacity, as we discuss at length below. Lawful medical violence is also a gendered phenomenon. The United Nations Committee on the Rights of Persons with Disabilities (the 'UN Committee') recently noted that women with disability experience higher rates of non-consensual medical interventions perpetrated against them on account of the interaction and intersection of their gender (Committee on the Rights of Persons with Disabilities 2015, [8]).

Women with disability 'are much more likely to experience forced/involuntary electroshock (ECT) than men with disability. … nearly *three* times as many women receiv[e] ECT [voluntary and involuntary combined] compared with men' (Frohmader 2015, 11; on ECT and women generally see Burstow 2006). It has been noted that 'women with disabilities in institutional settings are more likely to be subject to guardianship proceedings for the formal removal of their legal capacity. This facilitates and may even authorise forced interventions and other forms of violence' (Frohmader, Dowse, and Didi 2015, 8).

> [F]orced contraception through the use of menstrual suppressant drugs is a widespread, current practice in Australia, particularly affecting girls and women with intellectual and/or cognitive impairment [which is] widely used in group homes and other institutional settings, often justified as a way of reducing the "burden" on staff/carers who have to "deal with" managing menstruation of women and girls. (Frohmader and Sands 2015, 38)

As well as being violence in its own right, lawful medical violence (and the related detention or physical restraint in spaces in which such violence takes place) can increase the vulnerability of women to further violence including 'unlawful' violence such as sexual

assault and physical assault (Frohmader, Dowse, and Didi 2015, 16; Frohmader and Sands 2015, 46).

Consideration of lawful medical violence and the broader issue of violence against women with disability is now particularly pressing, given a number of co-occurring contemporary political developments which remain largely disconnected. These include increased domestic political recognition of violence against women (notably domestic violence), the recent Australian Senate Inquiry into institutional and residential violence against people with disability and recent international human rights developments recognising non-consensual medical interventions as breaching human rights. These developments are occurring in the context of a long-term campaign by disability advocates to have violence against women with disability, including non-consensual medical interventions, recognised as violence against women in Australia by Women with Disabilities Australia and People with Disability Australia (see, e.g. Dowse et al. 2013; Frohmader and Sands 2015), and internationally by such organisations as Women Enabled (see, e.g. Ortoleva and Lewis 2012; see also Center for the Human Rights of Users and Survivors of Psychiatry 2013).

We begin our interrogation of how non-consensual medical interventions against women with disability are a socially permissible form of lawful medical violence by drawing on scholarship in critical disability studies and feminist disability theory. We then discuss the legal permissibility of non-consensual medical interventions against women with disability by reference to the contouring of law vis-à-vis mental capacity and assess recent international human rights developments which identify non-consensual medical interventions as constituting multiple human rights abuses against people with disability and specifically women with disability. We conclude with a discussion of how the mainstream feminist movement might contest lawful medical violence as one aspect of a broader strategy to enhance its engagement with violence against women with disability.

Disability, medical bodies and medical management

One of the cornerstones of disability studies as a discipline has been its engagement with the medicalisation of disability and impairment, utilising an analysis which premises the social and material construction of disability. More recently, critical disability studies scholars have drawn upon a range of disciplines and theoretical standpoints to analyse the social, political and cultural dimensions of disability as a form of difference[1] which are key to the analysis of medicalised bodies. These scholars have contested the material, cultural and institutional ways through which disability as abnormality is produced and has effect, including the greater legal permissibility of violence against people with disability. Several key aspects of these debates are germane to our argument for recognition of and deeper feminist scholarly and political engagement with lawful medical violence against women with disability.

The first concerns critical disability studies' critiques of medical processes and systems of classification as the exercise of biopower. This Foucauldian analysis invites a contestation of the role of institutions of biopower including medicine, the psy-complex and the law and associated systems of legal and welfare regulation in the production of difference in general and the gendered disabled body in particular. Specifically, by their bifurcation of

normality and abnormality in the body politic these institutions and processes have been identified as forms of structural disablism (Reeve 2012) if not structural violence (Hollomotz 2013) in and of themselves. Given their disproportionate application to the gendered body (a point we take up in the following section), these processes constitute a legitimate and central concern to feminist scholarship.

The second critique is associated with the role of impairment and embodiment. Just as feminist scholarship has contended with the different conceptualisations of gender and the diversity of women, so too critical disability studies scholars have grappled with the need to 'take seriously the real, material and ontological realities of impairment' (Goodley 2011, 116), in particular that the impaired body is embodied, embedded and inherently social, political and in-process rather than natural, objective, purely biological and deterministic (Roets and Braidotti 2012). Medicalisation and medical intervention is intensified in some disabled women's bodies, in particular those whose impairments are associated with traits of mental incapacity and irrationality, such as those with cognitive and psychosocial disability, rendering lawful medical violence socially and legally permissible precisely because of these impairments and the related pathologisation of their behaviour and life circumstances.

We argue that in the contemporary 'rights/empowerment' era, the 'different' human rights thresholds for people with disability which 'accommodate' (and, discriminate against them on the basis of) their differences (Carey 2009) allow a focus on protection from risks attributed to the individual's impairment. Yet, this 'protection' paradoxically exposes people with disability to greater levels of violence and marginalisation as it manifests in modes of segregation, intervention and detention. These modes are rationalised on the basis of the protection they provide and are legally sanctioned through judicial oversight. In the contemporary context, medical interventions are re-framed as benevolent, protective and even empowering, a point we take up in detail in sections below. These insights from critical disability studies provide a compelling case for a feminist engagement with lawful medical violence against women with disability precisely because consideration of the anomalous body has the potential to challenge our understanding of *all* bodies (Shildrick 2012, 30).

Gender, disability and medical violence

Recent development of the terrain of feminist disability studies is associated with recognition of the need for feminist and disability scholars to resist and rewrite notions of weakness, lack and deficiency associated with both gender and disability. Claims that feminist disability studies re-imagines disability and in the process transforms both feminist theory and disability scholarship (Hall 2011) invite attention to the intensification of personal, social, political and cultural dimensions of othering where gender and disability intersect. Increasingly sophisticated and diversified critiques of patriarchy and medicalisation have enabled a more nuanced view of gendered disability, primarily through critiques given social and political weight because they emerged from disabled feminists. Feminist disability scholars have critiqued processes of medicalisation, drawing attention to the complex interplay of gender and disability. A cogent example of this is seen in critiques by some feminist disability theorists of the sterilisation, breast bud removal, growth attenuation and other medical procedures done to a girl with intellectual disability,

referred to as 'Ashley X', and the subsequent legitimation of these interventions by doctors, bioethicists and lawyers (see, e.g. Kafer 2013, ch 2). In the context of the link between violence and mental incapacity, the very act of denying an individual autonomy on the basis of mental incapacity is itself a form of violence in the form of epistemic violence (on epistemic violence and disability see Matthews forthcoming), which is then compounded by the material violence in the acts done to women's bodies pursuant to the decisions made by others on their behalf.

Medicalisation of women with disability can also result in the production of women as genderless and asexual (Frohmader 2015, [8]) and this becomes a basis for an affective response to medical intervention characterised by indifference to the specific gendered *and* disabled nature of the violence. Judith Butler discusses the concept of 'derealisation', whereby certain lives are discursively denied the status of a life worth 'grieving' because they do not fit within the 'dominant frame of the human' thus resulting in their dehumanisation which 'then gives rise to a physical violence that in some sense delivers the message of dehumanization that is already at work in the culture' (Butler 2004, 34). Drawing on Butler, it could be argued that women with disability, in being constructed as genderless and asexual, are subjected to derealisation not merely as 'humans' but specifically in the context of their status as gendered humans. Moreover, to the extent that medicalisation of women with disability relates specifically to violence vis-à-vis sexuality and reproductive capacities, implicitly women with disability are subjected to derealisation in terms of their capacity to be sexual and reproductive actors and to be gendered humans capable of reproducing grievable new life. It follows that in relation to women with disability, what is ungrievable is not merely the subjection of women with disability to violence generally but their subjection specifically to *gendered* violence. Butler's approach to the relationship between human, violence and affect can be used to understand one aspect of the complexity of the social permissibility of this violence: the lack of critical and political attention to non-consensual medical interventions in women with disability *as a form of violence against women* and as an *injustice* requiring a political and legal response.

'Lawful' medical violence against women with disability

We now turn to discuss how socially permissible non-consensual medical and gendered violence is also lawful or legally permissible. It is important to consider the lawfulness of medical violence against women with disability because this is one of the key points of differentiation between this form of violence and those which are unlawful such as sexual violence and domestic violence. This differentiation shows how non-consensual medical interventions are a form of violence that is so embedded in what is permissible within law and in society more broadly. This differentiation also highlights new sites for feminist theoretical and political intervention beyond a concentration on existing criminal legal categories of violence against women, notably the importance of recent shifts in international human rights law.

Understanding how medical violence is largely lawful begins with the foundational legal concept of legal capacity. Legal capacity is 'the basis for recognising an individual as a person before the law' (Beaupert and Steele 2015, 161). Legal capacity consists of the 'ability to hold rights and duties (legal standing) and to exercise those rights and

duties (legal agency)' (Committee on the Rights of Persons with Disabilities 2014, 3[13]). Attributing legal capacity to an individual is the basis for giving legal recognition to an individual's choices and decisions concerning their behaviour, how they live their lives and what happens to their bodies. The notion of legal capacity also protects individuals' bodies from interference by others – individuals can give and withhold their consent to contact made by others, and if others make contact without individuals' consent these acts can constitute criminal assault.

Not all individuals have legal capacity. Legal capacity is only granted when an individual has 'mental' capacity. Mental capacity has 'largely been assessed in terms of individualistic, internal psychological processes' (Beaupert and Steele 2015, 161). Individuals have been found to lack mental capacity 'by reference to diagnoses of mental and cognitive impairments' such that 'it is largely people with disability who are deemed mentally incapable and in turn are considered to lack legal capacity' (Beaupert and Steele 2015, 161). Thus, in law's recognition of an individual's autonomy over her body, the construction of mental capacity and the granting of legal capacity are intimately linked to the medical approach to disability discussed above.

Individuals with disability who are deemed to have mental incapacity and hence denied legal capacity do not exist outside of law. Rather, in being deemed mentally incapable of making decisions, and denied the legal capacity to choose what happens to them, the law provides schemes for *others* to make decisions on their behalf. This occurs in three legal modes: substituted decision-making schemes, lawful authorisation of treatment and detention and the defence of necessity. The effect of these legal modes in association with legal capacity means that non-consensual medical interventions do not constitute unlawful violence, that is, criminal offences, because the woman's lack of consent is legally irrelevant. Criminal law of assault is defined as *non-consensual* interpersonal contact and contact is not assault if it is consented to. Criminal law has developed in an ad hoc and socially contingent manner concerning 'consent' such that there are various exceptions to this general rule of consent which effectively mean that consent mediates interpersonal relations pursuant to dominant social norms. For example, criminal law did not recognise 'consent' to the physical contact of homosexual sadomasochistic activity but would recognise 'consent' to the physical contact of male contact sports such as rugby league (see discussion in Bibbings 2000, 237–243). In the case of individuals deemed to lack legal capacity, 'consent' can be legally provided by third parties pursuant to substituted decision-making schemes or be deemed legally unnecessary because of legislative schemes which lawfully authorise mental health detention and treatment. Moreover, the defence of necessity might apply on the basis that a woman with mental incapacity is in a permanent state of emergency and hence requires medical intervention irrespective of her wishes. By reason of these three modes, non-consensual medical interventions in relation to women with disability deemed to lack mental capacity are not criminal offences which can be prosecuted. This means that non-consensual medical interventions in women with disability are lawful by reason of the legal ordering of violence as lawful or unlawful by reference to mental capacity, and by the same reason, are disability-specific because they are only committed against people with disability by reason of the medical approach to mental incapacity (Steele 2014).

Moreover, the legal spaces and legal processes through which acts of medical violence are authorised by law negate their status as harmful and shape affective responses to

these acts as necessary and beneficial. This is by reason of the legal tests governed by seemingly benevolent considerations of 'best interests' and 'least restrictive alternative' and the broader role of legal process as providing judicial 'oversight' and procedural 'protections' (Steele 2014). Yet, this focus on the *process* through which decisions are made has come at the cost of any sustained consideration of the violence inherent in the *object* of the decisions and the *act* of making the decision with little clarity on the thresholds of what kinds of interventions should be *beyond* legal authorisation (Steele forthcoming).

The division in criminal law (and law more broadly) on the basis of legal capacity is foundational to how law orders violence, and the relationship of legal capacity (and this ordering) to a scientifically authentic mental capacity has been largely taken for granted. Critical disability studies scholarship provides the analytical tools to question the concept of mental capacity and the division of individuals along the divide of mental capacity and incapacity (Carey 2009; Steele 2014; Weller 2014, forthcoming). Mental capacity can be analysed as a socially and politically constructed concept based on norms, rather than an absolute and natural phenomenon. As such, it is not simply the *attribution* of mental incapacity to women with disability which is problematic vis-à-vis lawful medical violence, rather, it is the *existence* of mental incapacity *and* the legal capacity/incapacity binary in law which is the problem (Steele 2014, forthcoming).

It is acknowledged that individuals without disability might be subjected to non-consensual medical interventions pursuant to the defence of necessity,[2] if they are temporarily unconscious or to address an extreme and imminent short-term emergency (e.g. blood transfusion to an individual injured in a serious car accident, or an appendectomy following a ruptured appendix). Yet, direct comparisons between the status in the defence of necessity of individuals without disability and individuals with disability are impossible to make. This is because non-consensual medical interventions on women with disability are fundamentally different since they have a different purpose, are of a different kind and are in different thresholds and scales of temporality, particularly as to what is necessary and hence justifiable without consent of the individual. Criminal law constructs different legal subjects imagined on the basis of dis/ability and in/capacity and to these attach different thresholds of permissible violence in terms of the kinds of procedures, different localities of emergency and different temporalities. It follows that there are less legal avenues available to subject women without disability to lawful medical violence, at the same time that their differing status to women with disability means that the necessary 'equality' of comparison between the two categories of women is impossible such that viewing lawful medical violence against women with disability as discrimination is incomprehensible (Steele forthcoming).

Lawful medical violence as international human rights issue

Recent developments in international human rights law are offering a shift away from the status of non-consensual medical interventions in women with disability as socially and legally permissible. These developments reframe non-consensual medical interventions as violence and hence open new possibilities for political and scholarly engagement with violence against women with disability. Historically, people with disability have been subject to lower human rights thresholds by reason of their marginalisation in mainstream international human rights instruments and the existence of disability-specific international

human rights instruments providing lower human rights thresholds (Mégret 2008, 500). In particular, the division of human rights subjects on the basis of mental capacity and incapacity was routine and for individuals with mental incapacity the focus was on protection by ensuring procedural safeguards through which denial of legal capacity and substituted decision-making occurred, rather than 'protection' from violence inherent in the act of this decision-making or the acts done pursuant to these decisions

The United Nations Convention on the Rights of Persons with Disabilities (the Disability Convention) which entered into force in 2008 was premised on a 'concern' that 'despite [mainstream international human rights instruments] persons with disabilities continue to face barriers in their participation as equal members of society and violations of their human rights in all parts of the world' (Preamble, k). The Disability Convention is significant to the recognition of lawful medical violence as a breach of international human rights in four key ways. Firstly it redefines disability as an evolving, socially contingent concept (Preamble, e) thus challenging the pervasive medical approach to disability in the earlier mental incapacity human rights approach (Sabatello and Schulz 2014, 15–20). Secondly, it emphasises non-discrimination and equality, both as a right in itself (Article 5; see also Article 8.1b) and a general principle governing its operation as a whole (Article 3b). Thirdly, the Disability Convention recognises the significance of intersectionality (Preamble, p), including the intersection of gender and disability, recognising the multiple forms of discrimination experienced by women with disability (Article 6.2) and their greater risk of violence (Preamble, q). Fourthly, the Disability Convention challenges the way in which perceived mental incapacity results in denial of legal capacity by recognising the importance of individual autonomy and independence including the freedom to make choices (Preamble, n; see also Article 3a) and requiring that 'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life' Article 12.1 and 12.2). This shift in approach to legal capacity has been the concentrated focus of disability legal scholarship which closely examines the impact of these human rights shifts on *processes* of decision-making (see e.g. Arstein-Kerslake and Flynn 2016; Flynn and Arstein-Kerslake 2014; McSherry 2012; McSherry and Wilson 2015), but has given lesser consideration to the implications of these human rights shifts for the meaning of violence in domestic criminal and civil law frameworks (see however, Steele 2014).

In its guidance on the interpretation of the Disability Convention, the United Nations Committee on the Rights of Persons with Disabilities (the Disability Committee) has indicated that non-consensual medical interventions specifically in women with disabilities constitute human rights abuses. The Disability Committee has explicitly stated that non-consensual medical interventions constitute a violation of the right to legal capacity as well as 'a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16)' (Committee on the Rights of Persons with Disabilities 2014, 11[42]; for a critical perspective on disability and torture see Wadiwel forthcoming). The Disability Committee has stated that 'States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment' and recommends 'that States parties ensure that decisions relating to a person's physical or mental integrity can only be taken with the free and informed consent of the person concerned' (Committee on the Rights of Persons with Disabilities 2014, 11[42]). The

recognition of lawful medical violence as a human rights abuse provides a legal and political impetus for the prohibition of medical violence against women with disability.

The possibilities provided by developments in international human rights laws of challenging the social and legal permissibility of lawful medical violence against women with disability has met with resistance from the Australian government. For example, most recently, in November 2015 the United Nations Human Rights Committee 'raised concerns Australia is breaching the human rights of women with disabilities by allowing their forced sterilisation' (Jabour 2015). Yet, Australia remains steadfast in the legitimacy and continuation of these practices. Moreover, Australia has an interpretative declaration to the Disability Convention which includes its understanding that the Disability Convention 'allows for fully supported or substituted decision-making arrangements … only where such arrangements are necessary, as a last resort and subject to safeguards' and 'that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards'.[3] Thus lawful medical violence (particularly *gendered* forms such as sterilisation) remains embedded within the Australian social and legal fabric.

Feminism and violence against women with disability

This article has mapped some of the theoretical, legal and political contours of the status of non-consensual medical interventions in women with disability as lawful medical violence. The article has articulated why scholarly and political contestation of this particular form of violence is at a critical juncture. In closing, we reflect on the implications of our analysis for feminist scholarship and activism. In recent times, the increased political debate around 'violence against women' has prompted some disability rights advocates to ask whether violence against women with disability counts as 'violence against women' (Cadwallader, Kavanagh, and Robinson 2015). Some of this questioning has been squarely directed at mainstream feminist action (i.e. where agendas focus on women in general), which has been critiqued as ableist for explicitly avoiding considerations of violence against women with disabilities in the course of its contributions to public debate on violence against women (see, e.g. the discussion related to online Australian feminist campaign 'Destroy the Joint' in Connor 2015a, 2015b, 2015c; Ellis 2015).

One manifestation of this criticism is the issue of where violence against women with disabilities 'fits' in mainstream feminist engagements with 'violence against women'. Domestic violence, sexual violence and murdered women are issues which loom large in the contemporary Australian public arena, particularly the recent high profile Australian cases such as Rosie Batty and Jill Meagher. Feminist scholars and activists have been vocal in these issues, yet have largely ignored simultaneously prominent considerations of violence against women with disability, particularly lawful medical violence. One recent example is the absence of wider feminist engagement with law reform inquiries into violence against people with disability discussed above (Senate Community Affairs References Committee 2013, 2015), including one (2013) specifically on sterilisation. It could be expected that these law reform inquiries would be important sites for broad-based feminist engagement with violence against women, particularly because, as we

have previously pointed out, women with disability experience higher rates of violence than women without disability.

While it is beyond the scope of this article to provide an in-depth analysis of feminism's relationship to disability, we make two cursory sets of observations in an attempt to account for this resistance to engagement. Firstly, historically, mainstream feminist thought has identified the medicalisation and pathologisation of women's bodies as central to control, disempowerment and violence against women (see e.g. Chesler 1972; Ehrenreich and English 2010). This specifically includes both reading women's behaviour in terms of the attribution of individual, medicalised mental traits of incapacity and irrationality and the use of medical interventions on women's bodies. Interestingly, these very processes of medicalisation and pathologisation are associated with disability (as we discussed earlier) such that there is a clear intersection in the construction and oppression of women and of people with disability. Yet while these feminist critiques seem to be 'allied' in the sense of paralleling disability, rather than politically engaging *with* this intersection or with disability itself, mainstream feminist debate has largely overlooked or actively resisted its relationship to disability in the course of achieving equality for women on the basis of gender. Influential strands of feminist thought have successfully contested processes of medicalisation and pathologisation of women and the associated attribution to women of irrationality and incapacity, however, they have generally done so by *distancing* women as a gendered political category from these processes and characteristics, rather than providing a critique of them. As such, these forms of feminist engagement have focused on the wrongful *attribution of disability* to women (presumably 'normal', able, privileged women) rather than *politicising disability* itself, thus leaving disability as an individualised and medicalised dimension of identity which is, in turn, apolitical. For example, Vivian May and Beth Ferri state that

> to advocate for women's individual and collective rights, feminists have refused the analytic equation of womanhood and disability. … By definitively asserting that women are *not* disabled by their sex, many feminists have simply replaced one subject-object dualism (male vs female) with another: woman vs disability. This perpetuates a problematic mode of subjectification that erases women with disabilities'. (May and Ferri 2005, 120; see also Center for the Human Rights of Users and Survivors of Psychiatry 2013, 2)

At times, mainstream feminist argumentation has relied upon the exclusion and even abjection of disability to ground claims to equality, such as by asserting the rationality and capacity of women (in the context of feminism, see e.g. Schalk 2013, see a similar phenomenon identified in relation to critical theory and identity politics more broadly Erevelles 2011, 29–33, 36–37; Siebers 2008, 79–80, 193–194;). That said, it should be noted that the feminist research on 'debility' provides some promising possibilities for more widespread feminist engagement with the intersection of violence and different forms of embodiment and ability (see e.g. Puar 2009; Wearing, Gunaratnam, and Gedalof 2015). Kay Inckle has questioned the compatibility of debility with disability, arguing that it reflects a 'compulsory abledbodiedness' which negates the disabled body (Inckle 2015; cf the application of debility in a disability context by Fritsch 2015; and the qualified and nuanced support given by Shildrick 2015). The feminist work on critiquing vulnerability has drawn attention to the political, social and economic use of 'vulnerability' for surveillance, protection, coercion and intervention notably by reason of neoliberalism

(see recently Butler 2014). Yet, ultimately, within this more 'promising' mainstream feminist scholarship disability remains predominantly a trope and an abstract analytical tool rather than a reference to embodied women with disability and as such the mainstream of feminist scholarship is yet to offer a critique of or political engagement with the specifics of violence against women with disability across the complexities of its unlawful and lawful forms.

The second set of observations relates to the lack of depth in feminist exploration of violence against women with disability (*particularly* lawful medical violence). With the notable exception of the contributions of feminist scholars who are the mothers of disabled children (see e.g. Kittay 2009; Ryan 2013) who have challenged problematic medical intervention more generally, for many feminist scholars it might be that violence against women with disabilities falls well beyond the experiences and circumstances of women without disability. Much of the 'unlawful' violence against women with disability occurs in the context of relationships (e.g. formal carer relationships) or spaces (group homes, mental health facilities, prisons) which are specific to disability and not encountered by women without disability, particularly women with financial and educational privilege. To an even greater extent, lawful medical violence is removed from mainstream feminist scrutiny as it occurs in institutional circumstances rarely experienced firsthand by women without disability. Additionally, the legal circumstances in which such violence is enabled are unlikely to be encountered by women without disability who mostly have the legal capacity to consent to medical interventions in their bodies.

Following from the lack of general feminist engagement in violence against women with disability are a number of issues – deserving of much deeper discussion than we have the opportunity to give them here – about the relationships between gender and disability, between violence against women with and without disability, and between feminist and disability activism. Some of these were evocatively captured by board member of People with Disability Australia Samantha Connor (2015a) who wrote:

> When we are murdered, it is not violence, because it may not be the type of violence you know and understand.
>
> We are abused and murdered in places that you do not know about, in circumstances you're not familiar with.
>
> But there is this.
>
> We are still women, and we are just as raped, just as dead.

While we have outlined a number of concerning dynamics around feminist theoretical and political engagement with violence against women with disability, our focus here, pending a more detailed critique, is to urge the wider feminist mainstream to build upon the wealth of theoretical and political work already done in different political and disciplinary contexts. We ask feminist scholars to demand of their own work and that of others an account of violence against women with disability as violence against women and for violence against women with disability to matter – socially, politically, legally and intellectually. We suggest that broad-based feminist engagement with violence against women with disability necessitates the simultaneous 'gendering' *and* 'disabling' of women with disability, that is, *politicising* their sex and impairment and exploring the

complex intersections of these in their exposure to violence and in law's response to this violence. Central to the full recognition and contestation of *all* forms of violence against women with disability is to challenge the existing legal ordering of violence. Working *within* and fine tuning the existing legal architecture for unlawful violence (focused on sexual assault and domestic violence) will do nothing to contest (and may implicitly affirm) the lawfulness of non-consensual medical interventions and other lawful violence against women with disability. In this pursuit, mainstream feminism might turn to new sites and strategies for contesting violence against women with disability. This includes critiquing the *boundary* in law between lawful and unlawful violence and the significance of *capacity and disability* to that ordering, as well as the role of medical disciplines, professions and institutions in this process (e.g. through diagnosis) and in the ultimate enactment of the legally authorised violence. While outside the scope of our analysis, we would point to the intersections of bioethics, medicine and law, and the intersections of neoliberalism, health industries and law as key sites of potential mainstream feminist engagement with violence against women with disability. On a practical level, feminist scholars and advocates can engage in law reform inquiries and in public debate related to violence against women with disability, including in supporting recent demands for 'transitional' justice for people with disability who have experienced violence consisting of criminal prosecutions, reparations, institutional reform and truth commissions (Frohmader and Sands 2015, 34). In order to achieve any of this, at a fundamental level we call on the wider feminist mainstream to turn inwards to question its own implicit assumptions about the relationships between gender, ability and violence and reflect on how these condition both its present theoretical and political trajectories and the affective limitations of its response to violence against women with disability.

Notes

1. Note, however, the argument by Helen Meekosha and Karen Soldatic (2011), about the possibility of the selective and strategic deployment of medicalised impairment in contesting oppression (although we argue that lawful medical violence is not such a moment for the strategic deployment of medicalised impairment).
2. The other two modes applicable to women with disability – substituted decision-making and lawful authorisation – do not apply to women without disability as they are both dependent on mental incapacity and/or mental illness.
3. *Convention on the Rights of Persons with Disabilities: Declarations and Reservations (Australia)*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

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