



Center for the Human Rights of
Users and Survivors of Psychiatry

Comments on the draft update of CEDAW General Recommendation No. 19:

Forced psychiatric interventions as violence against women with disabilities

Tina Minkowitz, JD
26 September 2016

This submission urges the Committee to address forced psychiatric interventions against women and girls in its update of General Recommendation No. 19.¹ The Committee has condemned forced psychiatric interventions and institutionalization in its Concluding Observations, and two UN mechanisms have recognized the practice as a form of intersectional violence against women with disabilities.²

1. Psychosocial disability as gendered experience and labeling of distress

Forced psychiatric interventions target a subgroup of women with disabilities, i.e. women with psychosocial disabilities, those who experience or are alleged to experience mental health conditions.

Women and girls experience distress in a gendered manner, inseparable from the stress imposed on them in navigating the public and private spaces of a world dominated by men, in which women and girls are punished both for conforming to gender norms and for resisting them. Such distress includes the traumatic and post-traumatic effects on women and girls of rape and other sexual objectification and violence, which are emblematic of women's and girls' position in patriarchal society. It also includes the effects of society's hatred and contempt expressed towards lesbians, butch women, and girls and women who for any reason resist stereotyped clothing, activities, and behavior norms. Distress can be intense enough that the woman or girl views it as a mental health condition, or others around her view it as such. There is no inherent difference between those who label/are labeled as experiencing mental health conditions and those who are not; no woman's or girls' distress should be pathologized as abnormal, as this sets her outside the frame of solidarity with other women and the ability to know and politicize her condition.

¹ Please see www.chrusp.org for further information about the submitting organization; contact details for submission tminkowitz@earthlink.net. Thanks to Lucila Lopez, María Teresa Fernández, and Devorah Zahav for feedback and suggestions. For further background, see also <http://www.treatybodywebcast.org/crpd-14-public-side-event-on-violence-against-women-and-girls-with-disabilities-intersectional-and-double-violence-in-medical-and-institutional-settings-world-network-of-users-survivors/>.

² CEDAW/C/MDA/CO/4-5 para 38(d); CEDAW/C/IND/CO/4-5 para 37(a). See also CRPD General Comment No. 3 paras 31, 32, 51, 53-54, 62(a)(i) and (b)(ii), and Report of the Special Rapporteur on Violence Against Women, A/67/227 paras 31 and 38.

Women and girls are particularly at risk of psychiatric labeling when they assert themselves and express strong emotions such as anger, especially when they are in vulnerable situations such as being homeless, or subjected to multiple and intersecting discrimination as women and girls of color,³ and/or as lesbians. Despite the fact that lesbianism and male homosexuality are no longer officially considered mental disorders, mental health professionals may still question the validity of lesbian sexual orientation. A new form of medicalization of distress has arisen in tandem with psychiatric labeling, in particular the use of protocols that encourage social and medical transition for gender dysphoric women and girls.⁴ A number of women who have undergone such treatment have subsequently desisted from trans identification, identified the medicalized and social transition as harmful, and asserted that such treatments ultimately do not meet their underlying needs or provide satisfying relief from dysphoria.⁵

Women and girls with psychosocial disabilities have a right to be acknowledged as persons whose capacity for feeling, thinking, moral action, and interaction with their environment remains intact.⁶ They have the same rights as other women and girls to have and exercise legal capacity, in particular to construct their own narratives of self and to make decisions about health care and social services, including mental health services.⁷ Women and girls experiencing distress need to be offered support that respects their autonomy, will and preferences, and which they must have a right to refuse if unwanted. Alternatives to medical-model mental health services must be made available,⁸ including mutual support in female-only spaces with other women who have confronted similar life experiences.⁹

2. Forced psychiatric interventions as gendered invasion of bodily integrity, violation of bodily autonomy, and subordination to the will of others

Women who have experienced both violations compare forced psychiatric medication and forced electroshock to rape.

Women and girls are taught to expect to be raped and to submit to rape. Faced with the threat of forcible restraint in order to administer drugs or electroshock against her will, it

³ Shadow report to CERD submitted by Stephanie S. Franklin, African – American Girls in Foster Care & Psychotropic Medication: Her Right to Survival & Development, Bodily Integrity & Self-Determination, available at: http://www.ushrnetwork.org/sites/ushrnetwork.org/files/aa_girls_in_foster_care_psychotropic_meds_-_pdf_-_final_2-1.pdf.

⁴ See <https://4thwavenow.com>.

⁵ Female detransition and reidentification: Survey results and interpretation, <http://guideonragingstars.tumblr.com/post/149877706175/female-detransition-and-reidentification-survey>. See also blogs written by detransitioned women at crashchaoscats.wordpress.com, mariacatt.com, twentythreetimes.tumblr.com, hotflanks.wordpress.com, b0rnwr0ng.wordpress.com, redressalert.tumblr.com, womofthenorth.tumblr.com, guideonragingstars.tumblr.com, thissoftspace.wordpress.com, dopplershifts.tumblr.com.

⁶ CRPD General Comment No. 1 para 15.

⁷ CRPD General Comment No. 1 paras 8 and 42; CRPD General Comment No. 3 para 62(a)(i) and (b)(2).

⁸ CRPD General Comment No. 1 para 42.

⁹ For example, healing experiences over the forty years of the Michigan Womyn's Music Festival, as described in *Voices from the Land*, <http://www.michfestmatters.com>.

is not unusual to comply without resistance in order to avoid worse treatment. Such compliance is not true consent and is included in the concept of forced psychiatric intervention.

The action of mind-altering drugs on the body and consciousness creates a state of dissociation from self with potentially irreversible effects.¹⁰ The state of dissociation is gendered, as it reinforces the sexual objectification of women and girls as well as the patriarchal requirement that women and girls center others in their care and esteem leading to general self-objectification. The experience of drugs and electroshock as bodily invasions creating physical and mental sensations without consent is particularly akin to rape.¹¹

Electroshock and mind-altering drugs, particularly neuroleptics, were considered forms of torture as early as 1982 when applied to political prisoners.¹² Neuroleptic drugs “cause trembling, shivering, and contractions, but mainly make the subject apathetic and dull [the] intelligence,” and have been called a chemical straitjacket for the physical and emotional stiffness produced.¹³ In 2008, reconsidering the norms pertaining to torture and ill-treatment in light of the CRPD, Special Rapporteur on Torture Manfred Nowak recognized that the administration of electroshock or mind-altering drugs such as neuroleptics without the free and informed consent of the person concerned, could amount to torture or other ill-treatment not only in the case of political prisoners but in their routine usage against people with psychosocial disabilities.¹⁴ The CRPD Committee has affirmed that forced treatment including electroshock and chemical restraint violates the prohibition of torture and other cruel, inhuman or degrading treatment or punishment, and has noted that forced interventions are more likely to be perpetrated against women with disabilities than against men with disabilities.¹⁵

Physical tackling and forced administration of neuroleptics by injection, as well as physical restraints and solitary confinement, enforce subjection of women and girls to patriarchal institutional authority. Such measures of physical subjection render women and girls vulnerable to rape and other sexual abuse, and remind women and girls of their social position as victims of male violence powerless to defend their bodily autonomy. Typical restraints place the woman in a spread-eagle position on a bed with her legs spread open, unable to move her arms or legs. Solitary confinement deprives a woman of privacy and subjects her to impersonal gaze of male and female staff members in a state of physical and emotional vulnerability. Female staff members replicate the patriarchal model consciously or not, without considering the harm they are doing to their sisters of the same sex.

¹⁰ See Mother Justice, <https://tastethespring.wordpress.com/2016/07/31/mother-justice/>.

¹¹ *Id.*

¹² E/CN.4/1986/15, para 119.

¹³ *Id.*, see also section IIB of CHRUSP report to Human Rights Committee on nonconsensual psychiatric medication in the United States, available at <https://dk-media.s3.amazonaws.com/AA/AG/chrusp-biz/downloads/283810/CHRUSPUSICCPRshadowreportFINAL.pdf>.

¹⁴ A/63/175 paras 38, 40, 41, 44, 47, 61-63.

¹⁵ CRPD General Comment No. 1 para 42; CRPD Guidelines on Article 14 para 12; CRPD General Comment No. 3 paras 31, 32, 51, 53-54, 62(a)(i) and (b)(ii).

All women and girls have the right to bodily autonomy and integrity including freedom from forced or nonconsensual psychiatric interventions.¹⁶ States are obligated to end all forms of gender-based violence against women and girls, including violence based on both gender and disability. In particular, states are obligated to respect the legal capacity of women and girls with disabilities to make their own decisions about treatment and services related to emotional distress, and to take all necessary legislative, administrative and judicial measures to guarantee women and girls the legal right and effective means to defend themselves against unwanted psychiatric interventions.

3. Detention in mental health facilities or other institutions as gendered system of social control facilitating violence against women and girls

Involuntary commitment to mental health facilities is the foundation for the gendered system of social control described in this submission. The CRPD Committee and the Special Rapporteur on Torture have commented on the damage caused by involuntary commitment and involuntary treatment,¹⁷ which can have permanent and irreversible effects on a woman's mind, body, health, education, employment, intimate relationships, community involvement, and participation in political and public life.¹⁸ Even upon return to the community, she is viewed as a 'mental patient' and treated as if she is incompetent, fragile, violent, speaking nonsense, and unreliable;¹⁹ in most cases there is no support to heal the trauma caused by forced psychiatric interventions or to explore the politicized gender dimension of her life including psychiatric violence among other women. While there have been women's and feminist groups in the psychiatric survivors movement, and feminist groups that are open to survivors' knowledge, they are few and far between.

Social marginalization is exacerbated when family members instigate the psychiatric commitment. Women and girls, including many who are lesbian, butch, and otherwise gender-resistant, are generally embedded in family networks that exploit their emotional, sexual and practical labor, and considered burdens on the family when they cannot provide this labor and instead need support themselves. Family members call on psychiatry to manage the support needs the family cannot meet and suppress intra-familial conflict, without taking into account the punitive nature of such institutions or their exacerbation of women's and girls' distress. Institutionalization and confinement as a 'mad woman' or 'mental patient' is also used to discredit survivors of intra-family rape and other violence or abuse, as well as lesbians, gender-resistant women, and women who are perceived as dishonoring the family for any reason. The involvement of family members in the institutionalization of women and girls is further gendered in that the responsibility of providing support and managing the family's needs and resources falls on other female family members, who feel pressured to take coercive and restrictive action. Similar to psychiatric violence at the hands of female staff members, being institutionalized at the behest of female family members divides women from each other and deprives women

¹⁶ Id, see also CEDAW/C/MDA/CO/4-5 para 38(d); with respect to children see CRPD/C/DNK/CO/1 paras 20-21.

¹⁷ A/63/175 paras 47-50, 61-65; CRPD General Comment No. 1 para 42.

¹⁸ See Annex III to Report of OHCHR expert meeting on freedom from torture and persons with disabilities, <http://www2.ohchr.org/english/issues/disability/docs/torture/AnnexIII.ppt>.

¹⁹ See CRPD General Comment No. 30 and 47.

with psychosocial disabilities of female solidarity, disrupting and severing relationships they would ordinarily rely on throughout their lives. Multi-generational histories of psychiatric institutionalization, along with other socially marginalizing institutions such as criminalization and foster-care, are the result of the multiple forms of violence, abuse, and other discrimination against women and girls in patriarchal societies, and the inability of families and societal institutions to meet women's and girls' support needs or respond positively to demands for social transformation.

As this Committee has recognized in Concluding Observations, laws allowing involuntary hospitalization and institutionalization must be repealed;²⁰ courts also have a role to play in complying with the absolute prohibition of impairment-based detention under international law.²¹ All laws and practices that authorize deprivation of liberty based on an actual or perceived mental health condition (psychosocial impairment) violate the right to equal treatment under the law and the right to liberty and security of the person, which are guaranteed to women and girls with psychosocial disabilities on an equal basis with all other women, girls, boys, and men.²² This violation is not remedied by adding criteria such as alleged danger to oneself or others or alleged need for care and treatment.²³ Since the basis for application of these criteria is the person's actual or perceived mental health condition, they are discriminatory and cannot legitimize the deprivation of liberty.

The Committee can contribute to abolition of psychiatric commitment and forced interventions by condemning these practices as gender-based violence against women and girls, highlighting their impact on the enjoyment of all human rights and fundamental freedoms by women and girls with psychosocial disabilities, and the need for a gender perspective in developing support practices that fully respect women's and girls' autonomy and meet their needs free from patriarchal models of the family, medicine, social services, and the state.

²⁰ CEDAW/C/IND/CO/4-5 para 37(a).

²¹ Working Group on Arbitrary Detention, Basic Principles and Guidelines on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, A/HRC/30/37 paras 38-41 and 103-107.

²² CRPD Guidelines on Article 14, paras 4-6, 8.

²³ *Id.*, paras 7, 13-15. To elaborate further, 'danger to self' and 'care and treatment' criteria deprive persons with psychosocial disabilities of the freedom to take risks and make mistakes on an equal basis with others, which is an aspect of the right to legal capacity. The 'danger to others' criterion deprives persons with psychosocial disabilities of the right to equal guarantees in law enforcement and criminal proceedings when accused of endangering others, and subjects them instead to impairment-based preventive detention in civil commitment or to impairment-based security measures following a declaration of incapacity to stand trial or to be held criminally responsible. Human rights standards require necessary support and accommodations in law enforcement, criminal proceedings and detention settings, in order to ensure substantive as well as formal equality; restorative justice is encouraged but cannot require compliance with unwanted mental health treatment. CRPD General Comment No. 1 para 22; CRPD Guidelines on Article 14 paras 16-18, 20-21; WGAD Principles and Guidelines paras 107(a) and (b).

While the gendered aspects of criminalization are beyond the scope of this paper, women and girls with psychosocial disabilities who are accused of crimes are entitled to gender-sensitive approaches that take account of trauma and sex-based discrimination in their lives at all stages of proceedings, in detention settings, and in restorative justice programs. On gender and restorative justice, see Pamela Rubin, *Restorative Justice in Nova Scotia: Women's Experience and Recommendations for Positive Policy Development and Implementation – Report and Recommendations* (March 2003).