



## Regulation of disabled women's sexuality

By Nisha

The disability movement focuses on entitlements such as inclusive physical environments, employment, etc. But it scarcely discusses issues of the sexual lives of the disabled, which are denied, resisted and controlled at various levels

I began this paper by asking two of my colleagues, leaders in the disability movement in India, about their views on sexuality and disability. One response was: "You know better about the issues being faced by disabled persons here than to waste your time on sex-obsessed Western thinking." The other wondered: "...[Disability] still remains a kicked-off affair in the triangle of charity/welfare, medical rehabilitation and vocational training... When and how do we talk about sexuality?" I also remembered a comment that I heard two years ago, at a rehabilitation centre in Cuttack, about a woman with cognitive disability: "She just can't control... they take their eyes off her for a minute and she has done it with someone... Men! I tell you... Third pregnancy... can't even get a hysterectomy... and abortion at this stage is risky."

What are the ways in which the sexual lives of disabled women are denied, resisted and controlled at various levels?

Issues of disability and sexuality do not find a visible space in the disability discourse in India. The movement in India has focused on social change in terms of entitlements like inclusive physical environmental access, employment, and so on.

The public image of disability is that of a healthy and sharp young man in a wheelchair or of an alert and intelligent blind man, both of whom are disadvantaged only due to a physically inaccessible environment. Complicated issues like disabled persons' interaction with gender and other social, cultural oppressions, and the embodied experiences of physical, sexual and emotional rejection, wants and desires are not raised at all.

Within the disability movement there is a kind of vigilant silence about the wants and desires of the "impaired body". It is not just a negation of pain, fatigue, depression and illness but also a denial of dialogue about the body. This denial is blocking

opportunities of changing notions of attractiveness and attitudes towards disability and sexuality among the disabled themselves and in society.

### **The feminine body and appropriateness**

Feminists have engaged with three broad dimensions of the body: 'objectified bodies', 'regulated bodies' and 'bodies as texts'. Objectified bodies are not naturally but socially produced, reproduced and culturally inscribed. Women as objects of desire must be a 'perfect' whole of eroticised parts. 'Regulated bodies' police themselves to achieve the body ideal and control their own sexuality. 'Bodies as texts' exist in the dominant ideological/theoretical assumptions of the social system, which writes different roles for different types of bodies. Disabled bodies rendered deficient by objectification are subject to abuse, invasion and remodelling. In the process, disabled persons are expected to regulate their bodies to reach close to the body ideal, and discount the biological and subjective experiences of pain, illness, fatigue, age, and physical sexual complexities. The inability of disabled women to conform to the inscribed text of the ideal healthy "wholesome" body means the denial of 'normal' sexual and reproductive roles. An example of this is the attempt made in 1994 to perform hysterectomy surgery on 14 intellectually challenged women at the Sassoon General Hospital, Pune. The effort was seen as a way to manage menstruation and the consequences of sexual abuse, ie, pregnancy.

Closely linked to the notion of attractiveness are the issues of sexual access and the appropriateness of sexual desire and acts. Shakespeare, Gillespie-Sells and Davis dub the dominant form of 'appropriate sex' as heterosexual, penetrative, man-on-top sex. They find this oppressive for disabled persons who, because of difficulty with positioning and bodily dysfunction, may not be able to adopt it. But surely there is a possibility of non-genital sexuality, and other ways for the disabled to give or derive sexual pleasure?

### **Socialisation and information**

Anita Ghai, a disability rights advocate, recalls: "In the dominant north Indian culture, we are allowed to interact with our male cousins, but not share a room with them at night. When I was young, I was never stopped. Later I grew up and I realised that they had desexualised me because of my disability." Since the family and society do not recognise the sexuality of disabled persons, they do not recognise their need to engage in body and sexuality-related education or the need for information either. According to Meenu Sikand, in India, women with even simple disabilities do not get to learn about reproductive health because reproduction is linked to marriage and disabled women are not considered to have marriage prospects. There is a lack of

information *per se*, and wherever available the form in which the information is available is such that it remains inaccessible to many disabled persons. Lack of knowledge about sexuality results in confusion, guilt and silence, which affect self-esteem and the capacity for sexual self-actualisation.

### **Social construction of dependence and segregation**

The segregation that begins from infancy or the onset of disability is maintained by "special needs" institutions. Even in "special needs" institutions, disabled persons are infantilised. Sexual segregation of persons with cognitive disabilities may be cited as an example. Segregation is prompted by institutions and supported by families because they feel that the cognitively disabled are not capable of 'sound' personal decisions and lack the ability to take responsibility for relationships.

Equal opportunity policies meant to provide inclusive access have instead resulted in complacency and hypocrisy -- the pretence that a disabled person is *equal* and can be made *normal* if she/he is provided with a facilitative physical environment. Most social policies do not address attitudinal issues and fail to view and treat disability as normal. As a result, even in so-called 'inclusive environments', disabled persons remain isolated.

The support and protection needs of disabled persons not only make them vulnerable to abuse but also become grounds for infringing their right to sexual expression. Disabled persons lack leisure and privacy. Given the enormity of the barriers surrounding sexual relationships, disabled persons often find it easier to deny their sexual desires.

### **Sexual partnerships and relationships**

The denial of sexual identity to a disabled person implies that looking for a partner or acknowledging sexuality may make disabled women susceptible to being branded 'crude' or 'sex-mad'. This is so because their sexual desires disrupt set perceptions about disabled persons.

Considering the hurdles in finding a sexual partner from among the "able-bodied", one would assume that all disabled persons would opt for a disabled person as a partner. But the internalisation of notions of attractiveness by disabled persons means that disabled men may refuse disabled women as intimates. Stuart comments: "It's almost like a victory when disabled men go out with non-disabled women." The situation may not be very different for disabled lesbians. Asch and Fine suggest from their research that many disabled women indicate being rejected, shunned or relegated to a position of friend from being a lover.

Just as disabled women are considered asexual, they are also not seen as capable of long-term relationships. In the Indian context, it also explains the large number of existing sexual/marital relationships breaking up soon after the onset of disability. The assumptions regarding the capacity of disabled women to lead normal, ordinary lives also lead to a denial of the roles of reproduction and nurturing. The health sector does not give them information or access to facilities related to birth control, pregnancy or childbirth. Many states forbid persons with histories of epilepsy, cognitive disability and psychiatric disability from marrying. Some states allow the spouse to remarry without a divorce, in the event that a partner becomes disabled after marriage. For example, in India, the Hindu Marriage Act 1955 and the Special Marriage Act 1954 use terms such as 'unsoundness of mind', 'mental disorder' and 'insanity' to specify one of the circumstances in which a marriage can be rendered void, a divorce granted or remarriage sought.

Similarly, children are taken away from disabled persons, as they are not deemed fit and responsible enough to be mothers. Disabled women face discrimination in the adoption process, in the provision of foster care and in getting custody of their children after divorce.

The widespread use of eugenic measures in modern history and geneticists' support of eugenics suggest that disabled women are seen as sources of 'defects', and giving them the right to reproduce is regarded as burdening society with disabled children. The recent practice of prenatal testing and selective abortion of fetuses, in the likelihood that the child may have a health problem, puts the woman in a complex situation where the decision is not only about her body but also about a lack of confidence that, were she to give birth to a disabled child, she and her child would have fulfilling lives. These practices reinforce social prejudices and infringe on women's reproductive rights.

## **Conclusion**

Rendered deficient and regarded as unattractive, disabled women are denied socially inscribed sexual, reproductive and nurturing roles. This is a great disincentive for those disabled women who see sex and reproduction as integrated. And for women from cultures like India where marriage must precede sex and reproduction must follow sex. Denial of the reproductive role is denial of a sexual life.

Considering that so many negative perceptions about the sexuality of disabled persons go unchallenged, there is a need to carry out empirical work to reclaim the sexual experiences of disabled people. This must be done for three reasons: to substantiate the fact that disabled people are indeed perceived as asexual and face multiple barriers to their sexuality, and to make the non-disabled world accept and value

disabled persons' sexuality; to bring sexuality onto the disability movement's agenda; to validate the experiences of disabled persons. Positive cultural representations of the sexuality of disabled persons are important not only to change public perceptions but also to impact on disabled persons' access to sexually meaningful relationships.

***(Nisha is a women's rights advocate and a development worker committed to working towards ending violence against women and girls.)***

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