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Author Bios

Anna Darzins is a single mother of two teenage sons and a commuter from Sacramento. She is a transfer student from Sacramento City College, where she earned her Associates of Arts Degrees in Administration of Justice and Sociology. During her time at Cal, she has been a member of Phi Beta Kappa and Sigma Alpha Lambda Honors Societies. She is graduating from the School of Social Welfare with Honors, University High Honors with a Minor in Disability Studies. Currently Anna is conducting a research study through the Haas Scholars Program and investigating women with disabilities and their access to domestic violence services.

Alicia Gonzalez received her B.A. in Anthropology from the University of California, Berkeley in Fall 2013, with highest honors. "From the Past to the Present" was the culmination of her study in medical anthropology and her senior honors thesis. Prior to graduating, she was hired as an Analyst for the Graduate Division at UC Irvine and continues this position as full-time employment. She intends to attend a graduate program in public policy, focusing in health research, in Fall 2015

Kelly Jones graduated in December 2013 from UC Berkeley with a B.A. in South and Southeast Asian Studies and Geography. For the honors thesis she submitted under the advisorship of Dr. Penelope Edwards, then chair of the SSEAS department, she received High Honors and won the Chair's Book Prize, the highest prize offered by the department for an honors thesis. Currently she work as a staff member at the Bancroft Library while preparing to apply for graduate school to continue her studies in Malaysian and Singaporean governmental policies and racial relations.

Sophia Mao graduated from UC Berkeley in 2014 with a BA in English (summa cum laude) and Media Studies. As a junior, she worked with Professor Eric Falci in the English Department on his book project, The Cambridge Introduction to British Poetry, 1945-2010, where she discovered the fascinating intersections between British modernism and postcolonial studies. This paper, the culmination of a yearlong honors thesis on Virginia Woolf and the colonial imagination, features unpublished archival material from The Monks House Papers in Brighton, England. It was supported by travel grants from the English Department and Institute of International Studies and was advised by Professor Namwali Serpell, Professor Elizabeth Abel, and PhD Candidate Alexander M. Jeziorek. She is deeply grateful for their mentorship during the writing process.

Meg Perret is a fourth-year undergraduate student at UC-Berkeley studying Gender and Women's Studies, Integrative Biology, and Interdisciplinary Studies with a self-designed concentration in Science, Technology & Society. Meg is also an intern with the Gender Equity Resource Center and is involved with feminist, anti-violence, and anti-oppression activism and education.

Joshua Peterson graduated from UC Berkeley in August 2014 with a B.A. in English. During his time at Cal, he tutored the incarcerated at San Quentin State Prison through the Teach in Prison program and was a staff writer for Inqueery where he wrote blog articles pertaining to queer mental and public health. He currently lives in Berkeley with his partner, Mike, and hopes to pursue graduate studies in the near future.

Yunhee Roh came to the United States to pursue a degree in Sociology at the University of California, Berkeley. She recently graduated with the department's Highest Honors and will be applying this fall for a Ph.D. program in Sociology. In the gap year, she is currently working at the Center for Korean Studies at UC Berkeley and the Asian Art Museum in San Francisco. Working in these institutions allows her to continue to be deeply exposed to Korean Studies in both an academic and professional setting. It has also helped her to cultivate advanced skills relating to qualitative research and a wide array of methodologies to approach academic research that can be further developed in a Ph.D. program. She is passionate about topics surrounding gender studies, education, development, and data science.

Pablo Seward graduated from UC Berkeley with Highest Distinction in May 2014 with a B.A. in Psychology and Anthropology. He received the 2014 Kroeber Prize for the Outstanding Anthropology Senior Honors Thesis and the 2014 Judith Lee Stronach Baccalaureate Prize. Born and raised in Chile, throughout his stay in UC Berkeley Pablo got amply involved in research. He participated in four different URAP projects. In May-July 2013 Pablo became a SURF scholar and conducted research in Easter Island. He returned to Easter Island in January 2014 with an Institute of International Studies grant. Pablo was also active collaborating and creating new venues for research production, collaboration, and publication. He was Co-Chair of the Tourism Studies Working Group and created and organized the Anthropology Undergraduate Research Symposium, the first of its kind. Pablo also served as the Berkeley Undergraduate Journal Managing Editor, in which position his primary job was to publish the SURF conference proceedings; worked as correspondent for the Center of South Asia Studies; and created and taught a DeCal course on Easter Island in order to spark awareness of contemporary issues on the island. Pablo spends his free time playing tennis, and reading and writing fiction.

DOMESTIC VIOLENCE AND WOMEN WITH DISABILITIES

A Neglected Problem

Anna Theodora Darzins

Women with disabilities and women affected by violence have been seen as two different groups, when in fact, there is a tremendous co-occurrence to which service providers are not equipped to detect or respond. This thesis will explore the domestic violence experiences of women with disabilities to reveal important similarities and differences to women in general. Chapter one will begin by defining disability and exploring how the social context of disability interrelates with the social construction of femininity. The next chapter will focus on defining domestic violence, exploring women's experience of domestic violence, and enumerating special factors that may impact women with disabilities. The third chapter will discuss the types of existing services for domestic violence, the factors that complicate accessing services for this population of women, and the meaning of accessibility that goes beyond removing structural barriers. The final chapter will provide policy and practice recommendations and discuss significant gaps in the literature.

Keywords: impairment, functional limitation, disability, women with disabilities, internalized oppression, intimate partner violence, domestic violence, disability related abuse, disability services, accessible services, Americans with Disabilities Act, Violence Against Women Act, Crime Victim with Disabilities Awareness Act

Introduction

This thesis will begin by exploring the social context of disability to uncover social factors that are related specifically to having impairment, and in turn, having disability. The historical treatment of people with disabilities will be used as a lens to understand the current legislation that protects this population and some of the stereotypes that continue to persist today. Women with disabilities represent a large minority of women and make up the largest group of people with disabilities. By deconstructing femininity, we will explore how disability works to complicate the experiences of girls and women and inadvertently create conditions that make them more prone to abuse.

Chapter two will explore domestic violence and the similarities and differences in the ways that both women with disabilities and their non-disabled peers experience abuse. By discussing the factors that are specific to the abuse of women with disabilities, we will uncover some of the reasons this group is especially vulnerable. These factors will be used as a framework to understand how the added exposure to the abuse perpetrated by caregivers and the disability service system increases the isolation and dependence of women with disabilities.

Women with disabilities are more likely to be victimized and are unlikely to access domestic violence services; for these reasons, it is important for us to understand more about the service needs of this population. Chapter three will discuss the existing services and factors that complicate escaping abusive situations for women with disabilities. These factors can be used as a framework to reveal what domestic violence services need to include to adequately accommodate women with disabilities.

Finally, in chapter four we will discuss how current legislation is insufficient in addressing and responding to domestic violence, specifically for women with disabilities. We will explore practice recommendations that include the training of service providers to appropriately recognize and respond to the abuse of women with disabilities. Additionally, in conclusion, this thesis will discuss major gaps in research that are important in understanding the experiences of this population, in order to create relevant interventions addressing this social problem.

I.   Women with Disabilities

A.   *General Overview of Disability*

i.   Prevalence

According to the 2010 Census, approximately 56.7 million people in the United States, or 18.7% of the total population, have one or more disabilities.[1] Nearly 12.6 million of this group has severe disabilities, meaning they need the assistance of another person to perform physical functions.[2] The population of people with disabilities is expected to continue to increase, as medical and

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1   Matthew Brault. Americans with Disabilities: 2010 Household Economic Studies. (U.S. Department of Commerce, 2012).

2   Ibid. Lewis Kraus, Susan Stoddard and David Gilmartin. *Chartbook on Disability in the United States.* An Info Use Report. (Washington, DC: U.S. National Institute on Disability and Rehabilitation Research, 1996).

technological advances can extend their life expectancies.[3] The Centers for Disease Control and Prevention estimated that nearly 27 million people with disabilities are adult women who are 15 years or older.[4] The population of women with disabilities is greater than the population of men with disabilities because men are more prone to conditions that cause death, while women are more likely to outlive men by having primarily chronic conditions.[5]

People of color experience higher rates of disability than non-Hispanic Whites. The inflated rates of these minority groups can be linked to the high levels of poverty and decreased opportunities for employment and education. Native Americans face the highest disability rate: 21.8% have one or more disabilities.[6] Following closely behind, 21.7% of African Americans have one or more disabilities.[7] White non-Hispanics have a disability rate of 20.3%; Hispanics, 16.2%; and Asian/Pacific Islanders, the smallest, 10.7%.[8]

ii.   Preferred Terms

The term *disability community* is commonly used to refer to the community of disability activists, advocates, service providers, and people with disabilities. Throughout this thesis, the term *people or women with disabilities* will be used as it is preferred by the disability community, because it emphasizes the person before the condition.[9] This may appear to be a subtle difference, but because people with disabilities are used to others noticing and referring to them by their disability, the difference becomes quite meaningful.

iii.   Categories of Disability

Cognitive disabilities affect the brain, its functioning, and its development. This category includes *developmental disorders* and delays that occur when a person does not reach developmental milestones at the expected rate or has experienced a delay in the process of development affecting "gross fine motor skills, language, and social or thinking skills."[10] Autism is a complex array of neurological disorders that are characterized by social impairments, communication difficulties, and repetitive patterns of behavior. Psychiatric labels are commonly referred to as *mental illness*, which includes a wide range of disorders that affects a person's beliefs, moods, or perceptions not often shared by other people. People who have mental illness can have a diminished capacity to cope with what are thought to be ordinary life events or circumstances. Also included in this category are *learning disabilities*, which affect a person's ability to learn, retain, process, and remember information. Some of the disabilities in this category are not visible or obvious by looking at a person and are referred to as *invisible disabilities*.[11]

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3   Matthew Brault. Americans with Disabilities: 2010 Household Economic Studies. (U.S. Department of Commerce, 2012).

4   CDC | Women with Disabilities Disability and Health NCBDDD (2014)

5   Lita Jans and Susan Stoddard. *Chartbook on Women and Disability in the United States.* (An Info Use Report. Washington, D.C.: U.S. National Institute on Disability and Rehabilitation Research 1999).

6   Ibid.

7   Ibid.

8   Ibid.

9   Joseph Shapiro. No Pity: People with Disabilities Forging a New Civil Rights Movement. (New York: Times Books, 1993).

10   University of Michigan Health System. Developmental Delay: Your Child (2014).

11   World Health Organization. World Report on Disability. (2011).

The category of *physical* disabilities includes impairments that affect physical functioning, including the operation of organs, the muscular skeletal systems, and other tissue and vital bodily functions, such as respiration or cardiovascular processes. These impairments can limit or prohibit physical functioning and mobility or decrease stamina and dexterity. Some of these impairments occur at birth and are commonly called *congenital*, meaning they developed before or at birth.[12] They are often referred to as *birth defects*, such as physical deformities or asymmetrical body types. Other types of physical disabilities may present themselves later in life. It is common for this type of physical disability to be considered *acquired* after an event, like a head injury following an accident, or just to appear later in life with diseases, such as cancer, stroke, or even diabetes.[13]

Finally, there are impairments that can either prevent or complicate the ability to communicate. This category includes severe speech disorders that would make it difficult to be understood by others. Included in this group is sensory loss such as vision or hearing loss, which impacts the ability to communicate through either written or verbal methods. In some cases, hearing loss affects people's ability to learn spoken language because they are unable to hear the sounds that make words. These types of impairments may be congenital or acquired later in life either through disease or deterioration of organs, muscles, or tissue, or after an accident. There is great variation in the severity and ways that this category of impairment may be present. For example, a person with vision loss may still be able to see shapes and colors.[14]

iv.   Social Context for Disabilities

People may have one or multiple impairments that affect levels of disability differently. *Impairment* is a biological condition while *disability* exists in a larger social context.[15] This distinction can be confusing because we are accustomed to assume that disability and impairment is the same thing. A person may have cerebral palsy as an impairment and mobility as a *functional limitation* that requires him or her to use a wheelchair. This person becomes disabled when he or she face structural barriers in the built environment, like the lack of ramps into buildings.[16] Disability is actually a social process, since impairment does not essentially produce disability.[17] When impairment occurs in a social context that yields inaccessibility for a person with impairment, the person becomes disabled.

Since disability is not located within an individual person and is much more than a medical diagnosis, discussions about disability should include sociopolitical factors that impact disability status. Using systems theory, we can see how the ideology of public officials influences the availability and types of benefits offered by organizations that serve people with disabilities. This contributes to community attitudes, which plays into familial perspectives about the *abilities* of family members with disabilities.[18] This ultimately influences the way that people with

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12   Ibid.

13   Ibid.

14   Ibid.

15   David Braddock. Disability at the Dawn of the 21st Century: and the State of the States (American Association on Mental Retardation, 2002).

16   Ibid. Joseph Shapiro. No pity: People with Disabilities Forging a New Civil Rights Movement. (New York: Times Books, 1993).

17   Simi Linton. Claiming Disability Knowledge and Identity. (New York University Press, 1998).

18   Dean Hepworth and Ronald Rooney. Direct Social Work Practice: Theory and Skills. (Brooks/Cole, Cengage Learning, 2013).

disabilities view themselves and their capabilities.

There is great variation and diversity within this social group. Disability status is fluid and can change at any moment. Having a disability is part of the human condition and is likely to happen to most people within their life cycles.[19] Disability affects people in widely different ways: in addition to the social construction of disability, people have unique psychological responses to their impairments. Adding further to the complexity are the character and resilience of each person and the role this resiliency plays in his or her life. Throughout this thesis we should remember that we all have a vested interest in the treatment of people with disabilities because our designation as *nondisabled* is likely to only be temporary. Professor Michael Bérubé explains this well by saying:

> For 'disability' is the most labile and pliable of categories: it names thousands of human conditions and varieties of impairment, from the slight to the severe, from the imperceptible physical incapacity to inexplicable developmental delay. It is a category whose constituency is contingency itself. Any of us who identify as 'nondisabled' must know that our self-designation is inevitably temporary, and a car crash, a virus, a degenerative genetic disease, or a precedent-setting legal decision could change our status in ways over which we have no control.[20]

v.   Historical Perspectives on Disability

By understanding some of the historical treatment of people with disabilities, we can begin to connect how stereotypical beliefs have been institutionalized into our ideas of what having a disability means and why society often relates disability to tragedy. During the Medieval period, it was thought that having a disability meant that one had sinned and the disability was a judgment.[21] This group of people with disabilities was singled out and treated with prejudice by the majority because they were seen as a representation of evil.[22] It was not uncommon for people with physical impairments to be sold to "freak shows" where they were put on display. Their features were portrayed as grotesque and inhuman for the organizers to gain profit, often for the duration of their lives.[23] "People with disabilities have shared a history that has often been oppressive and included abuse, neglect, sterilization, stigma, euthanasia, segregation, and institutionalization."[24] In literary and artistic works, people with disabilities are often "portrayed as criminals or monsters or as people who are suicidal, maladjusted, or sexually deviant."[25] People with disabilities "are … seen as suffering punishment for doing evil; they are portrayed … as

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19   World Health Organization. World Report on Disability. (2011).

20   Simi Linton. Claiming Disability Knowledge and Identity. (New York University Press, 1998), Vii.

21   David Braddock. Disability at the Dawn of the 21st Century: And the State of the States (American Association on Mental Retardation, 2002).

22   Margaret Winzer and Lennard Davis. Disability and Society Before the Eighteenth Century: Dread and Despair. (New York Routledge, 1997).

23   Ibid. David Braddock. Disability at the Dawn of the 21st century: And the State of the States (American Association on Mental Retardation, 2002).

24   Ibid., 41

25   Margaret Winzer and Lennard Davis. Disability and Society Before the Eighteenth Century: Dread and Despair. (New York Routledge, 1997). 78

resentful of nondisabled people"[26]

The perception that disabilities were caused by sin and evil likely contributed to reasons that treatments that did exist were barbaric and cruel. The Romans believed that the blood of gladiators could cure disease, so it was common to line epileptics up to drink the blood of these slain men.[27] Treatment for deafness forced deaf people to shout so loudly that blood flowed from their mouths. This practice was thought to waken their latent hearing.[28] During the Renaissance, mental illnesses like depression, paralysis, and intellectual disabilities were treated by beating the patient on the head or even creating holes to remove "stones" or "black bile."[29] When a community became concerned that a person was likely to become a financial burden, he or she would be "warned out of town" and publicly whipped when he or she did not leave.[30] People with disabilities were more likely to receive this kind of warning because of their higher probability of being poor. Furthermore, this group experienced higher rates of punishment by public whipping because of their difficulty in leaving without financial means and the lack of physical ability due to their vulnerable health status.[31]

Early supports for poverty and disability came in the form of almshouses, which followed the tradition of Elizabethan Poor Laws.[32] These almshouses were intended to care for vulnerable groups such as children, the poor, the mentally ill, and people with other disabilities. To ensure that working and living independently was more desirable than living for free in almshouses, the living conditions were deliberately harsh. People lived in filth and barely had enough to eat.[33] A schoolmistress, Dorthea Dix, led reformers to demand better conditions after finding "people with mental illness and retardation 'in cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods, and lashed into obedience.'"[34] The response to the demand for better treatment of mentally ill patients was the beginning of asylums that were meant to be a place of rest and rehabilitation.

The Eugenics movement took the work of Charles Darwin on animal species and applied it to humans.[35] There was a concern that people with "inferior" genes were multiplying faster than the people with superior genes, and the response was to institutionalize and sterilize disabled people in an effort to control the population.[36] According to Shapiro, as the Eugenic ideology became popular, "Americans with mental retardation (called 'idiots' or 'feebleminded'), mental illness, cerebral palsy … were viewed as a menace that threatened to lower the health and intelligence of future generations."[37] Over 47,000 people were institutionalized and sterilized for reasons directly related to poverty and disability.[38] Persons with disabilities lived in poverty

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26 Ibid., 78.

27 Ibid.

28 Ibid

29 David Braddock. Disability at the Dawn of the 21st Century: And the State of the States (American Association on Mental Retardation, 2002).

30 Ibid.

31 Ibid.

32 Joseph Shapiro. No Pity: People with Disabilities Forging a New Civil Rights Movement. (New York: Times Books, 1993).

33 Ibid.

34 Ibid., 59.

35 Micheline Mason. Incurably Human. (Working Press, 2000).

36 David Braddock. Disability at the Dawn of the 21st Century: And the State of the States (American Association on Mental Retardation, 2002); Micheline Mason. Incurably Human. (Working Press, 2000); Joseph Shapiro. No Pity: People with Disabilities Forging a New Civil Rights Movement. (New York: Times Books, 1993).

37 Ibid., 158.

38 David Braddock. Disability at the Dawn of the 21st Century: And the State of the States (American Association

and were oppressed and discriminated against: they lacked access to medical care, received poor education, experienced higher exposure to filth and disease, and lacked access to proper nutrition resulting in greater rates of disability. Poverty and resulting isolation made this group more disabled; the cycle of inaccessibility, oppression, and poverty mutually reinforced one another to create unattainable social conditions for people with impairments.

vi.   Shifting Social Perspectives of Disability

After World War II, there was a shift in thinking about some specific types of disabilities. Some of the first programs focusing on rehabilitation of disability were for wounded soldiers who were seen as the "deserving disabled." Our society felt responsible for returning them as close to their prior normal functioning as possible because of their personal sacrifice.[39] In 1962, Ed Roberts was the first severely disabled student to enroll in the University of California, Berkeley. He faced opposition to his admission from the University and the Department of Rehabilitation, which did not want to accommodate him. The justification of their opposition was the assumption that he was too severely disabled to benefit from education and to become employable.[40] The response to his struggle to be accommodated led to the opening of the first Independent Living Center that served people with disabilities.[41] This center and subsequent movement sparked a shift in ideology, from viewing people with disabilities as patients in hospitals and at home to individuals who can live independently with some assistance in the community.[42] The Independent Living Movement "asserts that the disabled do not want to be relieved of their familial, occupational, and civic responsibilities in exchange for childlike dependency."[43] This movement focused on shifting the role of people with disabilities from patients to consumers and experts of their own needs.

vii.   Rehabilitation Act and ADA

In 1973, a single sentence statement in the Rehabilitation Act, Section 504, opened the doors to the first disability regulations requiring access and accommodation as a right for people with disabilities.[44] While Section 504 had passed, it was not immediately signed into law. This hesitancy prompted disabled groups to organize and protest; they took over a federal building, staged sit ins, chained themselves to buses, and climbed up the inaccessible stairs of the White House to create political pressure for Section 504 to be signed.[45] The notion behind this legislation was revolutionary because it placed responsibility on society to provide access to people with

on Mental Retardation, 2002).

39   Joseph Shapiro. No Pity: People with Disabilities Forging a New Civil Rights Movement. (New York: Times Books, 1993).

40   David Braddock. Disability at the Dawn of the 21st Century: And the State of the States (American Association on Mental Retardation, 2002).

41   Joseph Shapiro. No Pity: People with Disabilities Forging a New Civil Rights Movement. (New York: Times Books, 1993).

42   Ibid.

43   Gerben DeJong. Defining and Implementing the Independent Living Concept. Independent Living for Physically Disabled People. (Jossy-Bass Publishers, 1983). 18.

44   Ibid.

45   Joseph Shapiro. No Pity: People with Disabilities Forging a New Civil Rights Movement. (New York: Times Books, 1993).

disabilities and allow them to participate in their own private, civic lives and duties.[46]

According to Waxman-Fiuccia and Wolfe, "Disability rights law is based on the understanding that the problems which people with disabilities face are a consequence of segregation, poverty and discrimination rather than of personal defects or deficiencies."[47] Furthermore, in 1990, the Americans with Disabilities Act (ADA) was signed and created regulations against discrimination to safeguard the right to access and required the accommodation of people with disabilities.[48] According to the ADA, to qualify as having a disability, a person must "have substantial, as distinct from minor, impairment(s), and that these must be impairments that limit major life activities such as seeing, hearing, speaking, walking, breathing, performing manual tasks, learning, caring for oneself, and working."[49] For persons to access these rights and protections, they must disclose their disability status and also be able to provide documentation of their impairments.

Despite progress, stereotypes that effect people with disabilities persist. The objective of a stereotype is not to accurately represent reality, but instead to disguise and mystify actual social relations that "…are invoked to make racism, sexism, and other forms of oppression appear to be natural, normal and inevitable."[50] A common stereotypical belief about people with disabilities is that they are in bad health while in fact, "a person may need a wheelchair for help in moving or a respirator for help in breathing yet live a long and healthy life."[51] This inaccurate representation of their health status makes it easy to understand why it is common for society to believe that people with disabilities need to be cured.[52] When people with disabilities are seen as sick, it is quite natural for us to expect the medical profession to come up with a cure. Yet in most cases, a cure is impossible for people with disabilities, so this expectation sets them up for something they can never achieve.[53] Linton explains that another "… popular phrase *overcoming a disability* is used most often to describe someone with a disability who seems competent and successful in some way... while it … it seems that what is overcome is the social stigma of having a disability."[54]

viii. Current Circumstances for People with Disabilities

If people with disabilities have the legal right to access and accommodation, we would assume that this group would no longer be oppressed, stigmatized, or discriminated against. However, we find that people with disabilities are disproportionately under-educated, underemployed, and unemployed compared to their non-disabled peers.[55] The same regulations that are intended

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46 David Braddock. Disability at the Dawn of the 21st Century: And the State of the States (American Association on Mental Retardation, 2002).

47 Barbara Waxman-Fiduccia and Leslie Wolfe. Defining the Issues. Women and Girls with Disabilities. (Center for Women Policy Studies, 1999), 5.

48 Joseph Shapiro. No Pity: People with Disabilities Forging a New Civil Rights Movement. (New York: Times Books, 1993).

49 Henry Perritt. Americans with Disabilities Act Handbook (1991), 1.

50 Lynn Weber, Tina Hancock and Elizabeth Higginbotham. Women, Power, and Mental Health. (Ohio State, 1998), 383.

51 Joseph Shapiro. No Pity: People with Disabilities Forging a New Civil Rights Movement. (New York: Times Books, 1993), 262.

52 Ibid.

53 Edward Golub. Framing Health and Disease. The Limits of Medicine: How Science Shapes our Hope for the Cure. (Random House, 1994).

54 Simi Linton. Claiming Disability Knowledge and Identity. (New York University Press, 1998), 17.

55   Matthew Brault. Americans with Disabilities: 2010 Household Economic Studies. (U.S. Department of

to provide access to employment can have unintended consequence of discrimination in the employment application process. For example, people with disabilities may ask for accommodation they need when applying for jobs, but to get this accommodation the applicants/people with disabilities will have to disclose and document their disability, which reduces their chance of being viewed as a competitive choice for the job. These subtler types of discrimination are also present in racism; while they are not as overt, they can still be hurtful and harmful and generate the same exclusionary affects.

The World Health Organization found that children with disabilities are excluded from educational opportunities and thus placed among the poorest people in the world.[56] The 2010 Census statistics found that children with disabilities were more than twice as likely (30.1% of severe and non-severe compared to 8.8% of non-disabled children) to have less than high school diplomas.[57] This same census found that less than one-half, 41.1%, of individuals aged 21–64 with disabilities were employed, compared to 79.1% of people without disabilities in the same age group.[58] These high levels of unemployment also resulted in high poverty rates. According to Brault, during 2010, 28.6 % of people aged 15–64 with severe disabilities, 17.9% with non-severe disabilities, and only 14.3% of non-disabled people lived in poverty, and over half (53.1%) of people with severe disabilities experienced poverty for the last two years or more.[59]

Disparities begin for people with disabilities as young children who likely live in poverty with few educational opportunities. Special education programs are likely to be overcrowded and understaffed; thus, teachers of these programs do not have the resource nor the time to help the students with disabilities develop academic skills. The lack of skills then translates into having fewer options for employment later in life, which, in turn, ensures people with disabilities will remain in poverty. Living in poverty directly correlates with increasing likelihood of disability because of lack of good nutrition, limited access to medical care, and lack of financial resources. All these factors work together in a cyclical fashion to increase the chance of acquiring one or multiple disabilities, which will in turn increase their likelihood of having lower socioeconomic statuses, while raising their chances of living in deep poverty. This can be seen as a downward spiral cycle of disability and poverty (see Figure A, p. 11), where the nature of oppression and discrimination begets poverty, which begets disability and in turn begets more oppression and discrimination.

B.   *Women with Disabilities*

i.   Prevalence

Women with disabilities make up the largest percentage of people with disabilities. Women are more likely to live longer with chronic conditions than men, who are more likely to have conditions that cause early death.[60] It is estimated that nearly 1 in 5 women have disabilities that limit them

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Commerce, 2012).
    56 World Health Organization. World Report on Disability. (2011).
    57 Matthew Brault, Americans with Disabilities: 2010 Household Economic Studies. (U.S. Department of Commerce, 2012).
    58 Ibid.
    59 Ibid.
    60 Barbara Waxman-Fiduccia and Leslie Wolfe. Defining the Issues. Women and Girls with Disabilities. (Center for Women Policy Studies, 1999).

in one or more major life activities.[61] Women with a disability aged 20–64 were 10.2% of the total population in 2012.[62] Of this population of adult women with disabilities, 20.7% have less than a high school education.[63] In 2012, 28.4% of adults with disabilities lived in poverty compared to 12.2% of their non-disabled peers (Poverty in the United States, 2013). According to Waxman-Fiduccia and Wolfe, "While many women with disabilities derive enormous strength, resilience and creativity from their multiple identities, they also face the consequences of discrimination—low rates of employment, low wages, low educational levels, high rates of sexual and physical violence, and limited access to health services, including reproductive health care."[64]

ii.   Femininity, Women's Roles, and Disability

The social construct of femininity is deeply rooted in the image of being a good wife and mother while also being beautiful.[65] Women and girls without disabilities may be preoccupied with physical beauty, often regarded as a mark of their self-worth.[66] Women with disabilities face the same issues in terms of body image as women in general, but the former may face additional complicated issues related to disability, including scars, deformities, disfigurement, abnormal expressions and gestures, the presence of devices such as wheelchairs crutches, artificial limbs, braces, and devices for bowel and bladder management.[67] This social construct of femininity does not fit well together with the reality of disability, which complicates the lives of girls and women. Having a disability is likely to mean that girls or women with disabilities will be less likely to marry, become parents, and get jobs.[68] These obstacles obscure women with disabilities' sense of their own femininity and the way the society and their families perceive them.[69]

These feelings contribute to an *internalized oppression* that can be understood as the way persons receive societal and media messages of diminished self-worth until it becomes internalized and part of the way that they view themselves.[70] This internalized oppression contributes to why women with disabilities may view themselves as flawed, and not as socially desirable as their non-disabled peers. These complicated social constructions and how they intersect with the developing identity of girls and women with disabilities likely result in fewer choices in marriage partners, which explains why women with disabilities are less likely to be married than their non-disabled peers.[71]

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61   Ibid.

62   Disability Statistics. Disability Statistics. (Cornell University, 2013).

63   Ibid.

64   Barbara Waxman-Fiduccia and Leslie Wolfe. Defining the Issues. Women and Girls with Disabilities. (Center for Women Policy Studies, 1999), 3.

65   Deborah Kent. Women with Disabilities Essays in Psychology, Culture, and Politics. (Temple Union Press, 1988).

66   Sheryl Burt Ruzek, Virginia Olesen and Adele Clarke. Beauty Myths and Realities and Their Impact on Women's Health. Women's Health: Complexities and Differences (Columbus: Ohio State University Press, 1997).

67   Margaret Ann Nosek, Carol Howland, Diana H. Rintala, Mary E. Young and Gail Fraser Chanpong. "National Study of Women with Physical Disabilities: Final Report. "Sexuality and Disability" (2001).

68   Deborah Kent. Women with Disabilities Essays in Psychology, Culture, and Politics. (Temple Union Press, 1988).

69   Sheryl Burt Ruzek, Virginia Olesen and Adele Clarke. Beauty Myths and Realities and Their Impact on Women's Health. Women's Health: Complexities and Differences (Columbus: Ohio State University Press, 1997).

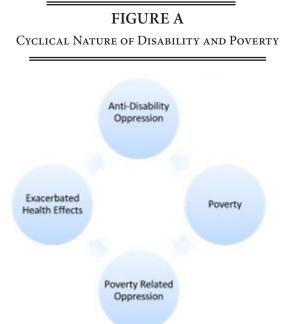70   Nadina LaSpina. Disabled Woman The Forging of a Proud Identity . Disability Culture in NYC. (1998).

71   Lita Jans and Susan Stoddard. *Chartbook on Women and Disability in the United States.* (An InfoUse Report. Washington, D.C.: U.S. National Institute on Disability and Rehabilitation Research 1999).

Girls and women with disabilities are often thought to lack the same range of life experiences as their non-disabled peers.[72] Frequently, society and family may inadvertently act in ways that are overprotective of women and girls with disabilities and intend to shield them.[73] For girls and women with disabilities, these actions are likely to inhibit their ability to develop their own perspectives and thoughts in the same ways and as fully as they would have without disabilities. Lack of life experiences and self-determination can set women or girls with disability up to being accustomed to someone else having control over their life and make them more vulnerable to abuse.

The Center for Research on Women with Disabilities (CROWD) found that overprotective parents and caregivers may prevent teens with disabilities from learning about and experiencing sexuality.[74] Girls and women with disabilities have less sexual knowledge and experience. The lack of sexual and reproductive knowledge is closely linked to the overprotection of women and girls with disabilities, who may not receive these facts because others do not feel these, are facts that they need, harkening back to Eugenic ideology.

Studies show that healthcare providers hold negative attitudes and are uncomfortable with women with disabilities who are seeking reproductive healthcare.[75] The discomfort and avoidance of families and healthcare providers in discussions about reproductive health increase the vulnerability of women with disabilities. The lack of this important information limits their ability to make informed decisions about parenthood or to protect themselves from fatal diseases. According to Waxman-Fiduccia, "it is estimated that at least 8.1 million families with children, or 10.9% of all American families, have one or more parents with disability."[76] These facts mean that women with disabilities do have sex and raise children and have families despite the social assumption that they are asexual.

FIGURE A

Cyclical Nature of Disability and Poverty

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72   Carolyn Vash. The Psychology of Disability. (New York: Springer Pub. Co., 1981).

73   Margaret Ann Nosek, Carol Howland, Diana Rintala, Mary E. Young and Gail Fraser Chanpong. National Study of Women with Physical Disabilities: Final report. Sexuality and Disability (2001).

74   Ibid.

75   Heather Becker, Alexa Stuifbergen, and Mindy Tinkle. (1997). Reproductive Health Care Experiences of Women with Physical Disabilities: A Qualitative Study . (Archives of Physical Medicine and Rehabilitation, 1997).

76   Barbara Waxman Fiduccia. Multiplying Choices: Improving Access to Reproductive Health Services for Women with Disabilities. (Center for Women Policy Studies, 1997), 5.

C.   Conclusion

In this chapter we have discussed how disability is much more than a medical diagnosis and how important it is for us to understand people within the context of their environment. There is a relationship among sociopolitical factors; structural barriers; and the ways people are treated by their community and family, their impairment, and personal characteristics and resilience that influence the ways they experience disability. The next chapter will use the social context of disability to uncover the factors that may inadvertently create conditions where women with disabilities, in particular, are more likely to become victims of abuse than their non-disabled peers.

II.   Women with Disabilities and Domestic Violence

A.   General Overview of Women's Experience with Violence

According to the National Violence Against Women Survey, 64% of abuse reported by women in the United States occurred in an intimate relationship.[77] The abuse that happens in an intimate relationship is commonly referred to as *intimate partner violence* (IPV) and *domestic violence* (DV). This chapter will include abuse that occurs in domestic settings where the abusive party is a family member, roommate, caretaker, or even personal assistant and will refer to all of these types of abuses as domestic violence.

The National Violence Against Women Survey estimated 1.5 million women experience physical or sexual violence each year in the United States.[78] Furthermore, the survey found that 15%–30% of the women had a prior history of domestic violence; this illustrates how often it not a single act of abuse, but more likely to occur repeatedly over a period of time.[79] The National Coalition Against Domestic Violence estimates that one in every four women will experience domestic violence in their lifetime.[80] These rates are likely to be conservative estimates because domestic violence is highly underreported to authorities and a source of stigma and shame for victims.[81] The prevalence of domestic violence will be discussed later in this chapter as it relates to women with disabilities specifically.

i.   Types of Abuse

The National Violence Against Women Survey defines *physical assault* as "behaviors that threaten, attempt, or actually inflict physical harm."[82] The survey defined *sexual assault* and *rape*

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77   Patricia Tjaden and Nancy Thoennes. Findings from the National Violence Against Women Survey. Full Report of the Prevalence, and Consequences of Violence Against Women. (2000).

78   Ibid.

79   Judy C. Chang, Sandra L. Martin, Katherine E. Moracco, Lisa Dulli, Donna Scandlin, Mary Beth Loucks-Sorrel, Tracy Turner, Leslie Starsoneck, Pattie Neal Dorian and Ingrid Bou-Saada. (2003). Helping Women with Disabilities and Domestic Violence: Strategies, Limitations, and Challenges of Domestic Violence Programs and Services. (Journal of Women's Health, 2003); Patricia Tjaden, and Nacy Thoennes, Findings from the National Violence Against Women Survey. Full Report of the Prevalence, and Consequences of Violence Against Women. (2000).

80   National Coalition Against Domestic Violence. Domestic Violence Facts: California. (2013).

81   Ibid.

82   Ibid, 5.

as "an event that occurred without the victim's consent, that involved the use or threat of force to penetrate the victim's vagina or anus by penis, tongue, fingers, or object, or the victim's mouth by penis."[83] A subtler form is *financial abuse*, which can be covert and uses tactics to limit the partner's access to assets or conceal information.[84] *Emotional abuse* is much harder to define because it can be covert, subtle or elusive; people often may not even recognize that they are being maltreated emotionally. This type of abuse can prohibit people from leaving the abusive situation. Emotional abuse also often occurs in the context of physical and sexual abuse. All forms of abuse are not mutually exclusive and often occur in simultaneously.[85]

ii.   Theoretical Models

Domestic violence is complicated because of a variety of definitions, causes, victims and perpetrators. The s*ocial learning theory* tells us that people model their own behavior according to behaviors they witnessed as children.[86] The *intergenerational cycle of violence theory* explains that vulnerability and exposure to domestic violence creates tomorrow's victims and perpetrators.[87] Using these theories as a framework to understand domestic violence, we can begin to recognize the intergenerational effects of abuse spanning through families.

According to Heise, "An ecological approach to abuse conceptualizes violence as a multifaceted phenomenon grounded in an interplay among personal, situational, and sociocultural factors."[88] We can imagine this as embedded levels of causality with multiple factors occurring on multiple ecological levels. For example, a personal history of witnessing abuse may be connected to male dominance within a family in the microsystem, which can be related to low socioeconomic status in the exosystem and acceptance of interpersonal violence within the macrosystem.[89] The diversity and variables that affect the likelihood of violence and abuse preclude simpler and single-factor theories of causation.[90] Instead by recognizing the array of potential reasons for an increased risk and organizing these factors according to their best fit in an ecological context, social workers can better assess and intervene in this social problem on multiple social and ecological levels.[91]

iii.   Social Impact of Domestic Violence

Each victim of domestic violence may experience the effects in very different ways because of the direct and indirect impact on the whole person both physically and emotionally. Abuse can consist of a combination of physical injuries, emotional trauma, sexual assault, intimidation and neglect. Abuse, therefore, is a public health problem that affects women and can cause injuries,

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83   Ibid, 4.
84   National Network to End Domestic Violence. About Financial Abuse. (2014).
85   Ibid.
86   Nicky Ali Jackson. (Ed.). Encyclopedia of Domestic Violence. (New York, NY: Routledge, 2011)
87   Ibid.
88   Lori L. Heise. Violence Against Women an Integrated, Ecological Framework . Violence Against Women (1998), 263.
89   Ibid.
90   Douglas A. Brownridge. Partner Violence Against Women With Disabilities Prevalence, Risk, and Explanations. Violence Against Women. (2006).
91   Ibid.

mental health problems, substance abuse, suicidal ideation or attempts, and even death[92] Acts of domestic violence carry physical and emotional effects for victims and witnesses and are considered as "act[s] of aggression and hostility against a whole person. This is not just a sexual act or a bodily violation, but an indignity, an invasion, and violation of a person that affects the victim physically, psychologically, and socially; an assault which does not necessarily end when the assailant leaves or is caught."[93]

On a macro level, domestic violence produces a high cost: increasing emergency room visits, inflating levels of unemployment, elevating the cost of social welfare programs, raising crime rates, overcrowding the justice and prison system, and flooding school systems that are unequipped to handle the numerous children who are either victims or witnesses of domestic violence. The National Coalition Against Domestic Violence estimates that domestic violence costs the state of California over $5.8 billion per year.[94] Rates of domestic violence highly correlates with substance abuse of both the perpetrator and the victim and their low socioeconomic status.[95] These factors make domestic violence an important social problem that needs to be addressed on both public and private fronts.

B.   *Women with Disabilities and Domestic Violence*

i.   Domestic Violence and Women with Disabilities: Special Factors and Considerations

In addition to the other forms of abuse mentioned, women with disabilities face added vulnerabilities to *disability related abuse* as a result of their disability status. This type of abuse includes assaults perpetrated by disability service providers and their staff, withholding of necessary assistance, and exploitation of the women's disabilities. For our purposes, domestic violence will refer to all forms of abuse mentioned, regardless of the perpetrator's identity: an intimate partner, family member, caretaker, paid attendant or disability service provider.

According to Waman and Fiduccia, "It is estimated that … 10.9% of all American families, have one or more parent with disability."[96] Nearly 1 of every 5 women in the United States has a disability, which makes women with disabilities a large minority of women who also experience domestic violence.[97] Although available research is minimal in this area, it suggests that women with disabilities do experience higher rates of abuse than their non-disabled peers.[98] General

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92 Sandra L. Martin, Neepa Ray, Daniela Sotres-Alvarez, Lawrence Kupper, Kathryn Moracco, Pamela Dickens, Donna Scandlin and Ziya Gizlice. Physical and Sexual Assault of Women with Disabilities. Violence Against Women (2006); Laurie E. Powers and Mary Oschwald. Violence and Abuse Against People with Disabilities: Experiences, Barriers and Prevention Strategies. Oregon Institute on Disability and Development (2004).

93 Sharon Milberger, Nathaniel Israel, Barbara LeRoy, Angela Martin, Linda Potter and Pam Patchak-Shuster. Violence Against Women with Physical Disabilities. Violence and Victims (2003), 583.

94 National Coalition Against Domestic Violence. Domestic Violence Facts: California. (2013).

95 Denise A. Hines, Kathleen Malley-Morrison, and Leila B. Dutton. Family Violence in the United States: Defining, Understanding, and Combating Abuse. (Sage, 2012).

96 Barbara Waxman Fiduccia. Multiplying Choices: Improving Access to Reproductive Health Services for Women With Disabilities. (Center for Women Policy Studies, 1997), 5.

97 Barbara Waxman-Fiduccia and Leslie Wolfe. Defining the Issues. Women and Girls with Disabilities. (Center for Women Policy Studies, 1999).

98 Sharon Milberger, Barbara LeRoy, Angela Martin, Nathaniel Israel, Linda Potter and Pam Patchak-Schuster. Michigan Study on Women with Physical Disabilities: Final Report. (National Institute of Justice, 2002); Margaret Ann Nosek, Carol Howland, Diana Rintala, Mary E. Young and Gail Fraser Chanpong. National Study of Women with Physical Disabilities: Final Report. Sexuality and Disability (2001); Laurie E. Powers and Mary Oschwald. Violence and

research trends estimate nearly 87% of women with a disability had been physically abused, 66% reported sexual abuse, 35% were refused help with personal needs, and 19% reported that they were prevented from using their assistive devices.[99] Preliminary findings suggest that domestic violence for women with disabilities tends to be more severe and occurring over longer periods of time.[100] Missing from the research are estimates of financial and emotional abuse, which is most difficult to quantify because of the elusive and oftentimes covert nature of this type of maltreatment. Domestic violence can be aggravated by existing impairments and, in turn, impairments themselves can be aggravated by domestic violence injuries.[101]

It is important to note that women with disabilities who have been victimized by domestic violence are more likely to have been abused as children. Physical and sexual abuse of disabled children is far more common than anyone can believe. According to Mason, "the idea that everyone who works with disabled children is kind, dedicated, and morally pure is no more than a fantasy. Also, it is hard for children, who already may have had their body manipulated…, to know when they are being abused."[102] Sobsey and Doe found that 39% of children with multiple disabilities had *known* prior histories of abuse.[103] The National Violence Against Women Survey results revealed that "women who reported they were raped before age 18 were twice as likely to report being raped as an adult."[104] This early and repeated exposure to abuse could likely desensitize women with disabilities into accepting it as part of an intimate or familial relationship.

ii.   Perpetrators of Abuse

Similar to their non-disabled peers, women with disabilities experience abuse perpetrated by not only intimate partners, but also family members, friends, and professionals and assistants with whom the women come into contact with.[105] Milberger et al.'s study, funded by the Department of Justice, revealed that a male partner was identified by the majority (80%) of the women as the abuser, followed by family member (31%), acquaintance (15%), and caretaker or health

Abuse Against People with Disabilities: Experiences, Barriers and Prevention Strategies. Oregon Institute on Disability and Development (2004). Oregon Institute on Disability and Development (2004); Dick Sobsey. Violence and Abuse in the Lives of People with Disabilities. (Baltimore: Paul H Brookes Publishing, 1994).

99   Sharon Milberger, Barbara LeRoy, Angela Martin, Nathaniel Israel, Linda Potter and Pam Patchak-Schuster. Michigan Study on Women with Physical Disabilities: Final Report. (National Institute of Justice, 2002); Margaret Ann Nosek, Carol Howland, Diana Rintala, Mary E. Young and Gail Fraser Chanpong. National Study of Women with Physical Disabilities: Final Report. Sexuality and Disability (2001); Laurie E. Powers and Mary Oschwald. Violence and Abuse Against People with Disabilities: Experiences, Barriers and Prevention Strategies. Oregon Institute on Disability and Development (2004). Oregon Institute on Disability and Development (2004).

100   Margaret Ann Nosek, Carol Howland and Mary Ellen Young. Abuse of Women with Disabilities: Policy Implications. (Journal of Disability Policy Studies, 1997)

101   Jill Radford, Lynne Harne and Joy Trotter. Disabled Women and Domestic Violence as Violent Crime. (Practice, 2006).

102   Micheline Mason. (1995) "The Breaking of Relationships." (Micheline Mason – Homepage, 1995), 5.

103   Dick Sobsey and Tanis Doe. Patterns of Sexual Abuse and Assault. (Sexuality and Disability, 1991).

104   Patricia Tjaden and Nancy Thoennes. Findings from the National Violence Against Women Survey. Full Report of the Prevalence, and Consequences of Violence Against Women. (2000).

105   Sharon Milberger, Barbara LeRoy, Angela Martin, Nathaniel Israel, Linda Potter and Pam Patchak-Schuster. Michigan Study on Women with Physical Disabilities: Final Report. (National Institute of Justice, 2002); Margaret Ann Nosek, Carol Howland, Diana Rintala, Mary E. Young and Gail Fraser Chanpong. National Study of Women with Physical Disabilities: Final Report. Sexuality and Disability (2001); Laurie E. Powers and Mary Oschwald. Violence and Abuse Against People with Disabilities: Experiences, Barriers and Prevention Strategies. Oregon Institute on Disability and Development (2004). Oregon Institute on Disability and Development (2004); Dick Sobsey. Violence and Abuse in the Lives of People with Disabilities. (Baltimore: Paul H Brookes Publishing, 1994).

professional (12%).[106] While identifying the perpetrators, one must consider the "social context of disability, including factors such as inaccessibility, reliance on support services, poverty and isolation," and lack of social supports and dependency as factors that increase the risk for violence.[107] Some researchers have hypothesized that it is by virtue of the exposure to potential abusers that risk of violence increases; in addition, some perpetrators may deliberately target vulnerable people who are unlikely to report abuse or gain credibility when they do report it.

iii.   Intimate Partner Violence for Women with Disabilities

The National Study from Baylor College of Medicine found that while women with disabilities were less satisfied with how often they date, 87% had at least one serious relationship and were significantly more likely to stay in a bad marriage than women without disabilities because of fears of losing custody of their children.[108] Martin et al. found that the most common perpetrators of domestic violence were ex-intimate partners, who are responsible for 44% of physical assaults and 48% of sexual assaults.[109] Since women with disabilities may have fewer opportunities for intimate relationships, these percentages imply that they experience disproportionate rates of abuse within intimate relationships.

Lenore Walker's cycle of violence theory has commonly been used as a framework to understand intimate partner violence.[110] This cycle has distinct phases that repeat and has been a tool used to assess situations of women experiencing violence.[111] Professor Copel from Villanova University found that women with disabilities experience a similar cycle of abuse, but with one very significant variation: their disability model lacks the "honeymoon phase."[112] Abuse episodes usually escalate from verbal attacks then culminate into an episode of violence, during which attacks are brutal, and women report damage to home and property and the confiscation of assistive devices like wheelchairs and medications.[113] Following the episode, the perpetrator would leave or separate themselves from the woman; one woman in the study referred to it as a "giant time-out."[114] For women with disabilities the abuse was not discussed as if it had ever happened until life returned to a "superficial" normal.[115]

According to Copel, "*All* of the women commented on the man's lack of acknowledgement that he had done anything wrong."[116] The perpetrators' lack of empathy or remorse for injury may be directly related to the abuse of women with disabilities since the women all reported the same

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106   Sharon Milberger, Barbara LeRoy, Angela Martin, Nathaniel Israel, Linda Potter and Pam Patchak-Schuster. Michigan Study on Women with Physical Disabilities: Final Report. (National Institute of Justice, 2002).

107   Laurie E. Powers and Mary Oschwald. Violence and Abuse Against People with Disabilities: Experiences, Barriers and Prevention Strategies. Oregon Institute on Disability and Development (2004), 2.

108   Margaret Ann Nosek, Carol Howland, Diana Rintala, Mary E. Young and Gail Fraser Chanpong. National Study of Women with Physical Disabilities: Final Report. Sexuality and Disability (2001).

109   Sandra Martin, Neepa Ray, Daniela Sotres-Alvarez, Lawrence Kupper, Kathryn Moracco, Pamela Dickens, Donna Scandlin, and Ziya Gizlice. Physical and Sexual Assault of Women with Disabilities. (Violence Against Women, 2006).

110   Leonre E. Walker. The Battered Woman. (New York: Harper & Row, 1979).

111   Linda C. Copel. Partner Abuse in Physically Disabled Women: A Proposed Model for Understanding Intimate Partner Violence. (Perspectives in Psychiatric Care, 2006).

112   Ibid.

113   Ibid.

114   Ibid.

115   Ibid.

116   Ibid, 121.

aversion of guilt by the perpetrator.[117] The women with disabilities in this study felt that "since their disability rendered them physically 'different from' or 'less than' other women, there was no compelling reason for the male partner to be remorseful."[118] The lack of acknowledgement by the intimate partner could be seen as a tactic to ensure the woman would remain complacent. As tensions built, the cycle would begin again, and the women reported that the situation never improved until they finally left.[119]

iv.   Sexual Assault

Sobsey and Doe reported that most people with disabilities who have experienced sexual assaults are women and most perpetrators are males.[120] Their study findings indicated that 81 of 100 women who reported sexual assault had a prior history of "major physical and or sexual assault."[121] Other studies estimated that having a disability increased the likelihood of experiencing sexual assault up to four times.[122] Research findings suggested that the increased risk could be related to the limited ability of the woman with a disability to defend herself, report the abuse, or recognize inappropriate behaviors.[123]

According to Sobsey and Doe's study, "49.6% of women with disabilities had been sexually assaulted over 10 times; 24.4%, up to ten times; and 20.4%, once."[124] These high rates of repeated sexual assault could be linked to the consistent exposure to the same caregivers and disability related service providers upon whom women with disabilities may rely. Because women with disabilities have limited access to social supports, care providers may overlook or misunderstand the signs of sexual abuse. For example, women in care homes that were sexually assaulted were punished for acting out, before anyone correctly interpreted realized their real intentions.[125]

v.   Disability Related Domestic Violence: Family Members and Caregivers

Women with disabilities who are taken care of at home by family members report lower rates of abuse, which is difficult to explain but possibly results from the following factors: shame, guilt of needing care, difficulty reporting because few opportunities to speak out, and reluctance to report the perpetrator who is a family member.[126] Research has suggested that learned helplessness or compliance makes these women easier targets.[127] Examples of this type of disability related

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117   Ibid.

118   Ibid, 124.

119   Ibid.

120   Dick Sobsey and Tanis Doe. Patterns of Sexual Abuse and Assault. (Sexuality and Disability, 1991).

121   Ibid.

122   Carri Casteel, Sandra L. Martin, Jamie B. Smith, Kelly K. Gurka and Lawrence L. Kupper. National Study of Physical and Sexual Assault Among Women with Disabilities. (Injury Prevention,2008).

123   Ibid; Sandra Martin, Neepa Ray, Daniela Sotres-Alvarez, Lawrence Kupper, Kathryn Moracco, Pamela Dickens, Donna Scandlin, and Ziya Gizlice Physical and Sexual Assault of Women with Disabilities. (Violence Against Women, 2006).

124   Dick Sobsey and Tanis Doe. Patterns of Sexual Abuse and Assault. (Sexuality and Disability, 1991), 247.

125   Ibid.

126   Laurie E. Powers and Mary Oschwald. Violence and Abuse Against People with Disabilities: Experiences, Barriers and Prevention Strategies. Oregon Institute on Disability and Development (2004). Oregon Institute on Disability and Development (2004).

127   Sharon Milberger, Barbara LeRoy, Angela Martin, Nathaniel Israel, Linda Potter and Pam Patchak-Schuster. Michigan Study on Women with Physical Disabilities: Final Report. (National Institute of Justice, 2002); Dick Sobsey.

domestic violence include "exerting power and control in the dispensing or withholding of medication [as] an intentional prolonging of pain alongside withholding or misusing aids, like wheel chairs or hearing aids which compound the isolating impacts of domestic violence."[128] Likewise, caregivers and paid attendants who work in the private homes of women with disabilities are also threats to multiple victims.

According to Milberger et al., "the very dependence, which can breed abuse, also creates a barrier to terminating the abusive situation because to do so would leave the woman without essential support services" if they spoke out.[129] Other complicating factors may include fears that she may be removed from her home and taken to a nursing facility because of a lack of options for placement when escaping an abusive family member.[130] This fear may silence women with disabilities because their care needs leave them with an even more undesirable option. In addition, the study from Baylor College of Medicine revealed that in some cases abuse perpetrated by family members is not deliberate, but a response to their frustrations and inability to cope with stress, fatigue, anger, and jealousy.[131] These frustrations likely stem from the limited resources available to care for their family members with disabilities.

vi.   Disability Related Abuse in Disability Service Settings

Abuse by disability related service providers can occur in private homes or care institutions.[132] This is different than the caretaker or paid attendant relationship because it usually occurs within a context of providing a specific service. The disability service provider may not necessarily provide daily care to the women with disabilities. Unlike paid attendants who are employed by the people with disabilities and paid public or private agency, these types of service providers are employed by agencies. Based on the reports of abuse, Sobsey and Doe's study found that 36.7% of abuse reported occurred in environments that the woman encountered as a result of their disability.[133] Their estimates suggest that including disability related abuse with domestic violence increases the likelihood of being victimized by an additional 78%, due to the exposure to "disabilities service system."[134] This type of abuse is typically perpetrated by people whom the woman with a disability does not have a personal relationship, and acts of abuse usually use the impairment as part of the abuse.[135]

Violence and Abuse in the Lives of People with Disabilities. (Baltimore: Paul H Brookes Publishing, 1994).

128   Jill Radford, Lynne Harne, and Joy Trotter. Disabled Women and Domestic Violence as Violent Crime. (Practice, 2006), 236.

129   Sharon Milberger, Barbara LeRoy, Angela Martin, Nathaniel Israel, Linda Potter and Pam Patchak-Schuster. Michigan Study on Women with Physical Disabilities: Final Report. (National Institute of Justice, 2002), 3.

130   Laurie E. Powers and Mary Oschwald. Violence and Abuse Against People with Disabilities: Experiences, Barriers and Prevention Strategies. Oregon Institute on Disability and Development (2004). Oregon Institute on Disability and Development (2004).

131   Margaret Ann Nosek, Carol Howland, Diana H. Rintala, Mary E. Young and Gail Fraser Chanpong. National Study of Women with Physical Disabilities: Final Report. (Sexuality and Disability, 2001).

132   Gill Hague, Ravi Thiara and Audrey Mullender. Disabled Women, Domestic Violence and Social Care: The Risk of Isolation, Vulnerability and Neglect. (British Journal of Social Work, 2011).

133   Dick Sobsey and Tanis Doe. Patterns of Sexual Abuse and Assault. (Sexuality and Disability, 1991).

134   Ibid.

135   Douglas A. Brownridge. Partner Violence Against Women With Disabilities Prevalence, Risk, and Explanations. (Violence Against Women, 2006); Gill Hague, Ravi Thiara and Audrey Mullender. Disabled Women, Domestic Violence and Social Care: The Risk of Isolation, Vulnerability and Neglect. (British Journal of Social Work, 2011).

Hague, Thiara and Mullender surmise the severity of disability related abuse correlates with the additional vulnerability caused by frailty, illnesses, age and immobilization.[136] Some unique vulnerabilities to abuse experienced by women with disabilities include social stereotypes of asexuality and passivity, lack of adaptive equipment, inaccessible home and community environments, increased exposure to medical and institutional settings, and inability of physically leaving the abusive environment.[137] Disability related abuse is an added vulnerability for women with disabilities specifically. While this abuse may seem different from domestic violence at first, it is likely to have the same effects upon victims because it is occurring with repeated exposure within the context of a working relationship.

C.   Conclusion

This chapter shed light on the similarities and differences of domestic violence for both women with disabilities and their non-disabled peers. Although all women have increased risk for intimate partner violence and domestic violence, women with disabilities may be particularly vulnerable and face higher prevalence rates over their life and possibly more severe types of violence and related impacts. In the final chapter of this thesis, we will explore the "goodness of fit" between women with disabilities who are exposed to violence and the existing network of services for women who have experienced intimate partner or domestic violence.

III. Domestic Violence Services

A.   General Overview

i.   Institutional and Societal Responses to Domestic Violence

The abuse of women by husbands and families used to be considered a private issue that was not society's business.[138] During the 1970's feminist movement, the private abuse of women became a public problem that had to be addressed; this is because women lacked the resources to escape violent and dangerous situations at home.[139] The rise of public awareness was an important shift recognizing the needs of women who were abused and marking the beginning of the Women's Shelter Movement.[140] This new grassroots movement was initiated by activists who focused on the elimination of male perpetrated violence against women by providing the abused women a temporary safe place to stay.[141] Shelters primarily relied on private funding and were run by a few staff members and volunteers.[142] Little has changed today; shelters receive limited government

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136 Ibid.

137 Margaret Ann Nosek, Carol Howland and Mary Young. Abuse of Women with Disabilities: Policy Implications. (Journal of Disability Policy Studies, 1997); Margaret Ann Nosek, Carol Howland, Diana H. Rintala, Mary E. Young and Gail Fraser Chanpong. National Study of Women with Physical Disabilities: Final Report. (Sexuality and Disability, 2001).

138 Patricia Tjaden and Nancy Thoennes. Findings from the National Violence Against Women Survey. *Full Report of the Prevalence, and Consequences of Violence Against Women.* (2000).

139 Nicky Ali Jackson. (Ed.). *Encyclopedia of Domestic Violence.* (New York, NY: Routledgee, 2007).

140 Ibid.

141 Jackson, Nicky Ali (Ed.). *Encyclopedia of Domestic Violence.* (New York, NY: Routledgee, 2007).

142 Ibid.

funds, but are still mainly grassroots privately funded organizations.

As the issue of domestic violence gathered more attention by society, more laws were created to address the abuse of women. Society responded by creating laws recognizing the abuse of women. According to Jackson, the "Violence Against Women Act of 1994" was "the first and most comprehensive federal legislation to address violence against women in the history of the United States."[143] For the first time, this act addressed the punishment for abuse, the privacy of the victim, and the restitution to victims of domestic violence. This act provided equal protection to women across all fifty states against gender-based violence.[144]

ii.   Factors Related to Escape

There is great variation in the way that people experience and understand domestic violence. Some of the variation is a result of different types of abuses inflicted on victims, the level of severity of the abuse, and the impact of emotional abuse in particular. According to Barnett, in order to attempt to leave an abusive partner, the battered woman must first "traverse several changes in beliefs: (a) acknowledging the relationship is unhealthy, (b) realizing it will not get better, (c) experiencing some catalyst (e.g., severe injury), (d) giving up the dream of an idealized relationship."[145] Changing these beliefs often takes time, during which the victims continue to experience an increasingly severe and chronic sequelae of maltreatment by the abusive party.

Although leaving an abusive environment may prove the safest long-term strategy for many severely battered women, it can pose very high, immediate risks to them in the short-term. This escalation of violence by the perpetrator can occur for many reasons, such as the perpetrator's fear and anger about losing control, the guilty party's realization that others may learn about their abusive behavior, the abuser's panic of losing custody of children, and even concerns of being criminally prosecuted. Ola Barnett's study found that up to 75% of women who were killed by their partners were in the process of terminating their relationship at the time of their murder.[146] In some instances, leaving may lead batterers to kill themselves, their children, and their partners in an act referred to as family annihilation.[147]

After deciding to leave, the women must meticulously plan and consider many factors, such as the ability to create a safe escape plan, the control of the perpetrator, a safe place to go, the loss of employment and custody of children, and the lack of financial resources. It is not uncommon for the process of leaving to take many attempts; in fact, some estimates have found that it is common for victims to escape and return an average of 5 times or more before finally leaving permanently.[148] First attempts may rely on informal supports from families and friends; when informal supports are not able to facilitate a permanent escape, formal supports become essential.

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143   Ibid, 719.

144   Ibid.

145   Ola W. Barnett. "Why Battered Women Do Not Leave, Part 1 External Inhibiting Factors Within Society." (*Trauma, Violence, & Abuse*, 2000), 345.

146   Ibid

147   Andrew R. Klein. *Practical Implications of Current Domestic Violence Research: For Law Enforcement, Prosecutors and Judges.* (Office of Justice Programs, US Department of Justice, 2009).

148   Ola W Barnett. "Why Battered Women Do Not Leave, Part 1 External Inhibiting Factors Within Society." (*Trauma, Violence, & Abuse*, 2000); Sabrina Rubin Erdely. Why I finally left. (*Good Housekeeping*, 2011).

iii.   Domestic Violence Services, Barriers, and Helpfulness

Domestic violence services usually include some combination of the following services to victims: 24-hour crisis hotlines, drop-in individual and group counseling, legal advocacy with civil and criminal remedies, short-term emergency shelters, and community education and outreach.[149] Shelter is a critical feature of services for battered women. It offers a safe refuge for women and their children and leaves the women time to think about their options and begin to rebuild their lives with social and legal assistance.[150] The entire continuum of services is often staffed by volunteers and paraprofessionals who work directly with women seeking help. In some cases, these paraprofessionals may be supervised by professionals such as social workers or lawyers.

Researchers suggest that the common barriers in accessing these types of services are lack of financial resources, time, and awareness of what is available.[151] Other access barriers include shame, isolation, and loss of privacy, and embarrassment, which can be amplified due to emotional abuse.[152] According to Bennett, Riger, Schwew, Howard and Wasco, when victims are able to access formal services, they report several benefits, including an improvement in their decisio$n making ability, an increase in their self-efficacy and coping skills, and a feeling of safety at the shelter.[153]

B.   *Women with Disabilities and Domestic Violence Services*

i.   General Overview

Neither the Women's Shelter Movement nor the Violence Against Women Act recognized or mentioned the need for protection against abuse for women with disabilities. The Crime Victim's with Disabilities Awareness Act, is the first of its kind, concentrating on "public awareness of the plight of victims of crime with developmental disabilities…."[154] This act focuses on the collection of data in order to quantifying the problem, and uses this information to develop strategies addressing the safety and justice needs of this population.[155] While this act recognized the need to raise awareness of this issue, it did not provide specific recommendations or regulations. Moreover, the disability community has criticized that it did not address gender-based violence nor include a diversity of disabilities, only the pervasive developmental disabilities.[156]

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149   Larry Bennett, Stephanie Riger, Paul Schewe, April Howard, and Sharon Wasco. "Effectiveness of Hotline, Advocacy, Counseling, and Shelter Services for Victims of Domestic Violence a Statewide Evaluation." (*Journal of Interpersonal Violence*, 2004)

150   Ibid.

151   Michelle Fugate, Leslie Landis, Kim Riordan, Sara Naureckas, and Barbara Engel. "Barriers to Domestic Violence Help Seeking Implications for Intervention." (*Violence Against Women,* 2005).

152   Ibid.

153   Larry Bennett, Stephanie Riger, Paul Schewe, April Howard, and Sharon Wasco. "Effectiveness of Hotline, Advocacy, Counseling, and Shelter Services for Victims of Domestic Violence a Statewide Evaluation." (*Journal of Interpersonal Violence*, 2004).

154   Crime Victims With Disabilities Awareness Act. *U.S. Government Information GPO*. (1998), 2838.

155   Ibid.

156   Barbara Waxman-Fiduccia and Leslie Wolfe. "Violence Against Disabled Women." *Center for Women Policy Studies* (1999).

ii.   Domestic Violence Services for Women with Disabilities

Isolation from society and an absence of informal social supports for women with disabilities make it critical for us to understand the service needs of this population when seeking help for domestic violence. Accessing social support is difficult for all women who are being abused, but especially difficult and complicated for women with disabilities due to physical limitations, social isolation from friends and or family, and limited situations where women who are being victimized may meet new people.[157] With little access to social support systems and networks, women may be forced to look to formal services for support in escaping abusive situations**.**

      For battered women with disabilities, going to shelter relies primarily on two factors: 1) that they know resources are available; and 2) that those resources are accessible and offer relevant disability-related accommodations. Those accommodations may include a wide range of adjustments including accessible buildings, doorways, bathrooms, showers, and meeting rooms; American Sign Language interpreters; print materials available in Braille, large print, and materials that are understandable for various levels of literacy; the provision of personal attendants; and access to psychiatric medications. Because agencies and organizations that serve battered women are typically grassroots organizations, they may not have the resources to increase their accessibility, and will mean fewer accessible services for women with disabilities. According to Milberger et al. "…only a small proportion of women with disability (16%) successfully sought and received adequate help to resolve their crisis situations."[158] As a result of this "poorness of fit" between the needs of battered women with disabilities and the continuum of services, these women are more likely to remain in chronically abusive situations that escalate in the level of severity over longer a period of time.

      In addition, although women with disabilities typically have some sort of disability related service providers such as social workers, therapists, doctors, and paraprofessionals, these service providers may not recognize or respond accordingly to the signs of intimate partner violence or disability-related domestic violence. According to Radford, Hame, & Trotter (2006), "… most disability agencies knew little about their clients' experiences of domestic violence."[159] Just as professionals and paraprofessionals who respond to gender-based violence may be unaware of the special needs of women with disabilities, professionals and paraprofessionals who provide disability-related services may have little cross-training in interpersonal violence.[160] Consequently, women who have both sets of concerns—living with disability and being exposed to intimate or disability-related domestic violence—may be overlooked in each continuum of service for "the other problem."

iii.   Women with Disabilities and Inaccessible Shelters

Currently, due to the high and growing demand for shelters, bed availability becomes a problem

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157   Cheribeth Tan, Joanne Basta, Cris M. Sullivan, and William S. Davidson. "The Role of Social Support in the Lives of Women Exiting Domestic Violence Shelters An Experimental Study." (*Journal of Interpersonal Violence*, 1995)

158   Sharon Milberger, Barbara LeRoy, A. Martin, N. Israel, L. Potter and Pam Patchak-Schuster. "Michigan Study on Women with Physical Disabilities, Final Report." (*National Institute of Justice, US* 2002), 16.

159   Jill Radford, Lynne Harne and Joy Trotter. "Disabled Women and Domestic Violence as Violent Crime." (*Practice,* 2006), 241.

160   Gill Hague, Ravi Thiara and Audrey Mullender. "Disabled Women, Domestic Violence and Social Care: The Risk of Isolation, Vulnerability and Neglect." (*British Journal of Social Work* 2010).

for women suffering from domestic violence.[161] Even under the requirements of the American's with Disabilities Act, state laws, and local ordinances, shelters that are frequently financially struggling still cannot ensure that these services are accessible to women with disabilities. Despite legal protection, Sobsey and Doe found that just over 50% of the services "failed to provide any accommodation to the special needs of the individual with a disability" while "another 22.8% were viewed as inadequately attempting to meet the special needs" of women with disabilities.[162] Moreover, a study on domestic violence services found that "…in relation to mental health, it is necessary to balance the woman's needs with those of other residents, raising issues of confidentiality;" sometimes a woman would have to be referred out because of fears that her mental health could not be managed.[163] Doubts of not being allowed to stay and to participate fully in shelter services may prevent women with disabilities from seeking services or disclosing the full extent of their accommodation needs.

iv.   Women with Disabilities and Counseling Services

Counseling is commonly provided by domestic violence services, offering women an opportunity to address the trauma caused by domestic violence.[164] Each service provider may use a different method, such as the feminist and social services models of care, cognitive restructuring therapy, assertive communication, problem solving, body awareness, vocational counseling, education about women's issues, gender socialization, self-esteem building, concrete plan development, trauma therapy, and grief-resolution-oriented counseling.[165] Studies have found that "counselors are most helpful when they directly discuss the violence and unconditionally accept the client's definitions of the situations."[166]

While counseling is often a service offered to women experiencing domestic violence, it is important to point out that it is underutilized: only 15% of women used this service.[167] A meta-analysis of the literature found that there is a prevalence of mental illness associated with being a victim of trauma: "47.6% with depression, 17.9% with suicidality, 63.8% with post-traumatic stress disorder, and 18.5% with alcohol abuse."[168] These findings indicate that being a victim of trauma will likely lead to the development of mental illnesses or disabilities. None of the findings specify whether women with disabilities were also receiving counseling, or whether or not counselors were trained in working with women with disabilities regarding issues of abuse and associated trauma.

161   Margaret Ann Nosek, Carol A. Howland and Mary Ellen Young. "Abuse of Women with Disabilities Policy Implications." (Journal of Disability Policy Studies, 1997).

162   Dick Sobsey and Tanis Doe. Patterns of Sexual Abuse and Assault. (*Sexuality and Disability,* 1991), 250.

163   Jill Radford, Lynne Harne and Joy Trotter. "Disabled Women and Domestic Violence as Violent Crime." (*Practice,* 2006).

164   Larry Bennett, Stephanie Riger, Paul Schewe, April Howard and Sharon Wasco. "Effectiveness of Hotline, Advocacy, Counseling, and Shelter Services for Victims of Domestic Violence a Statewide Evaluation." (*Journal of Interpersonal Violence*, 2004).

165   Ibid.

166   Jacqueline Dienemann, Jacquelyn Campbell, Karen Landenburger and Mary Ann Curry. "The Domestic Violence Survivor Assessment: A Tool for Counseling Women in Intimate Partner Violence Relationships." (*Patient Education and Counseling,* 2002), 228.

167   Kris R. Henning and Lisa M. Klesges. "Utilization of Counseling and Supportive Services by Female Victims of Domestic Abuse." (*Violence and Victims*, 2002).

168   Ibid, 633.

v.   Complicating Factors in Seeking Services Because of Disability Status

According to Milberger et al., only 33% of women with disabilities had sought support from formal domestic violence services.[169] Nearly half of the women indicated that they had tried but the service providers were not able to resolve their situations (e.g., they called the police but no action was taken; the shelters could not accommodate their disability).[170] Women with disabilities also face fears associated with having to make difficult decisions about leaving or taking their children along to the shelter and possibly losing them to Child Protective Services, who often consider women with disabilities incapable of providing appropriate care for their children.[171] Whether these women are able to access medications and assistive devices they need in order to survive can prolong their ability to successfully go to stay at a shelter. Women with disabilities report fears of losing their independence and being sent to a group home or nursing home because they cannot return their homes, and shelters are not able to accommodate them.[172]

C.   Conclusion

This chapter began by discussing the institutional and societal responses to domestic violence and factors that complicate the escape from abusive environments. Then by discussing the types of services provided for victims of domestic violence, we uncover the ways that service provision for domestic violence varies for women with disabilities. Finally, by discussing complicating factors that are specific to women with disabilities, we discuss some of the factors that may be directly related to why they are less likely to access domestic violence services.

Providing services for all victims of abuse is critical in addressing ways to reduce the negative impact on individual lives and society. Knowing that women with disabilities are more likely to be victimized and yet have less access to services is why it is imperative for us to understand more about the service needs of this population. In the next chapter, we will examine a set of recommendations that may help to decrease the gap between service needs and barriers of access for this group of women.

IV.   Recommendations for Policy, Practice, & Research

A.   Policy

It is imperative to provide additional funding to current legislation that specifically address the need for the detection and service provision for women with disabilities. Currently, legislation only addresses parts of this social problem, contributing to invisibility and unawareness of

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169   Sharon Milberger, Barbara LeRoy, Angela Martin, Nathaniel Israel, Linda Potter and Pam Patchak-Schuster. "Michigan Study on Women with Physical Disabilities, Final Report." (*National Institute of Justice, US* 2002).

170   Ibid.

171   Barbara Waxman-Fiduccia and Leslie Wolfe. "Violence Against Disabled Women." *Center for Women Policy Studies*, 1999)

172   Sandra Martin, Neepa Ray, Daniela Sotres-Alvarez, Lawrence Kupper, Kathryn Moracco, Pamela Dickens, Donna Scandlin and Ziya Gizlice. "Physical and Sexual Assault of Women with Disabilities." (*Violence Against Women*, 2006); Laurie E. Powers and Mary Oschwald. "Violence and Abuse Against People with Disabilities: Experiences, Barriers and Prevention Strategies." (*Oregon Institute on Disability and Development,* 2004).

this issue. The Violence Against Women Act does not allocate funds for shelters and domestic violence agencies to develop services that are accessible and relevant for women with disabilities. The Americans with Disabilities Act does not address issues related to abuse and or require accessibility of shelters that do not receive government funding. The Crime Victims with Disabilities Awareness Act exclusively includes people with developmental disabilities and thus excludes a large proportion of people with disabilities who are made to seem not as vulnerable or in need of protection.

Moreover, funding public health campaigns would also create national dialogue and awareness of the severity of domestic violence for women with disabilities. Campaigns would begin by educating the society so that this topic is viewed as a social problem that needs additional funding and resources. In addition, women with disabilities would need to become aware that services that they can access do exist, and domestic violence services would need to realize that this is a population they should include. Public health campaigns should use a combination of mainstream media and networks that women with disabilities ordinarily use.

B.   Practice

i.   Training of Physicians

While women in general are less likely to formally report abuse to the criminal justice system, they often seek medical care for injuries.[173] Identification of abuse when the women are disabled may be even harder to recognize especially when the perpetrator of abuse is present. Medical providers often speak to caregivers and not to the patients with disabilities; by doing so, the providers likely allowed the abusive party to explain injuries and limited the opportunity for a woman to report abuse. Medical staff should be trained in recognizing abuse that is perpetrated on people with disabilities by utilizing universal screening, offering women with disabilities opportunities to report abuse.[174] Moreover, special attention should be given to the assessment of unexplained injuries and psychological markers, such as depression and anxiety.

ii.   Personal Assistance and Disability Service Staff

Agencies that provide services to persons with disabilities should be expected to appropriately screen their staff, volunteers, and persons on their referral lists in order to reduce the number of predatory and abusive service staff. Additional recommendations include anonymous reporting of perpetrators to agencies for investigation, an on-call pool of personal assistants who could step in and provide care in emergencies, and training of disability related service providers and paid attendants to recognize abuse and respond protectively to suspected abuse.

iii.   Training of Law Enforcement and First Responders

Law enforcement and first responders, such as paramedics and fire fighters, are the first to arrive

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173   Patricia Tjaden and Nancy Thoennes. Findings from the National Violence Against Women Survey. (*Full Report of the Prevalence, and Consequences of Violence Against Women*, 2000).

174   Wendy G. Goldberg and Michael C. Tomlanovich. "Domestic Violence Victims in the Emergency Department: New Findings." *Jama* 251, no. 24 (1984)

at a scene of violence. Their professional interpretation of events and assessments of risk often sets the stage of how situations will be handled. The summaries and representation of events are often the basis of whether or not any intervention in a situation is considered necessary. Criminal justice agencies typically focus on difficulties women have in the context of reporting and prosecuting the incident and may not understand the complicating factors of reporting or escaping.[175] Therefore, the training of law enforcement, paramedics and fire fighters is a crucial element in the recognition and understanding of how to identify and respond to women with disabilities who are victims of domestic violence. Such trainings should include routine abuse and violence screening for people with disabilities, safety planning for women with disabilities, and knowledge in the appropriate types of referrals for women with severe disabilities who may need daily living assistance.[176]

iv.   Training of Legal Services

Researchers have found that legal remedies are less available for women with disabilities.[177] Impairments and disability could hinder these women's ability to access legal services that are commonly used when they are seeking assistance with legal matters concerning abuse. Often women with disabilities are not able to afford to hire private attorneys and must rely on free services. Agencies that offer free legal services are not usually mobile and require their clients to come to their offices, which could be complicated and even impossible for women with disabilities. Recommendations here include training legal service providers in working with women with disabilities, offering mobile services that may come to the women, ensuring that disability service providers have knowledge of the legal services available to women with disabilities, and providing women with disabilities with assistance in communicating with police and district attorney's offices.[178] Providing these service would ensure that women with disabilities have appropriate assistance in getting restraining orders, educating women with disabilities on how protective orders work, and training women how to respond to perpetrators who violate these orders.[179]

v.   Accessible Shelter Services

Access to a shelter gives victims who may be also escaping with children the choice to leave without becoming homeless. For women with disabilities, safe escape plans can be complicated by functional limitations and difficulty finding shelter that can appropriately accommodate them. Recommendations for accessible domestic violence services include barrier-free information and referral services using alternative formats, 24-hour access to transportation, 24-hour crisis line for individuals to talk with an advocate experienced in disability and victim services to get assistance with safety planning, access to American Sign Language interpreters for communication

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175   Jill Radford, Lynne Harne and Joy Trotter. "Disabled Women and Domestic Violence as Violent Crime." (*Practice,* 2006).

176   Laurie E. Powers and Mary Oschwald. "Violence and Abuse Against People with Disabilities: Experiences, Barriers and Prevention Strategies." (*Oregon Institute on Disability and Development,* 2004); Jill Radford, Lynne Harne and Joy Trotter. "Disabled Women and Domestic Violence as Violent Crime." (*Practice,* 2006).

177   Gill Hague, Ravi Thiara and Audrey Mullender. "Disabled Women, Domestic Violence and Social Care: The Risk of Isolation, Vulnerability and Neglect." (*British Journal of Social Work* 2010).

178   Margaret Ann Nosek, Carol A. Howland and Mary Ellen Young. "Abuse of Women With Disabilities Policy Implications." (*Journal of Disability Policy Studies,* 1997).

179   Ibid.

assistance, cross-training with disability related services, and the inclusion of trained personnel to monitor risks and respond to victims receiving services through disability programs.[180] These recommendations would improve the service to women with disabilities escaping abuse while also reducing the burden on hospitals, emergency rooms, and assisted living facilities, which typically receive these victims while not being adequately trained to serve survivors of trauma.

vi.   Parents

For children who have congenital or early onset of disability, parents play an important role in the ways that children with disabilities are treated and learn to view themselves. Parents of these children often do not have disabilities themselves and need assistance in understanding how to raise children with a healthy sense of self and expectations of others in an anti-disability society. Parents must learn to advocate for their children, help them establish agency over their body, encourage a sense of assertion and self-efficacy, and yet help them navigate a world of education, employment, and social relationships that may be full of bias.

vii.   Women with Disabilities

It is critical that interventions, training, and resources include women with disabilities so that they may exercise their capacities to prevent and identify violence and abuse. Most current resources in this area are directed toward training agency providers and protective services professionals to recognize abuse and to intervene to protect victims.[181] Recommendations here include training women with disabilities to recognize abuse, linking them with support from peers, referring women to advocates and professionals they can trust to assist them, affirming their right to be safe, teaching them to feel comfortable in trusting themselves to use the tools and supports available to them to manage abuse.[182]

C.   *Gaps in Research*

The current research in the area of women with disabilities and domestic violence is relatively limited in scope. While women with psychiatric labels are victimized at equal or higher rates than women with physical or developmental disabilities, this group is essentially missing in the research of women with disabilities and domestic violence. We can make assumptions that perpetrators of abuse monopolize on the limited or confused cognitive functioning of these women and feel secure that the women would not be believed if they speak out. The lack of attention to the experiences of women who have psychiatric labels or mental illness in disability studies and domestic violence literature implies that women with mental illnesses could be an even more socially isolated subpopulation of this larger group of women with disabilities.

There is evidence that documents the financial abuse and exploitation of older adults.[183]

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180   Ibid; Jill Radford, Lynne Harne and Joy Trotter. "Disabled Women and Domestic Violence as Violent Crime." (*Practice,* 2006).

181   Laurie E. Powers and Mary Oschwald. "Violence and Abuse Against People with Disabilities: Experiences, Barriers and Prevention Strategies." (*Oregon Institute on Disability and Development,* 2004).

182   Ibid.

183   Ron Acierno, Melba A. Hernandez, Ananda B. Amstadter, Heidi S. Resnick, Kenneth Steve, Wendy Muzzy

While there are parallels to the type of assistance needed by older adults and people with disabilities, we can only infer that having a disability along with dependence may also increase vulnerability to financial abuse. Since the financial abuse of persons with disabilities is missing in the literature, we have only anecdotal evidence of how people with a disability may be financially manipulated by payees and family members who are in charge of their finances. Understanding this abuse is pertinent to our knowledge of the types of control that is perpetrated using financial means on women with disabilities, which may limit a woman's ability to escape.

Throughout this thesis we have discovered that women with disabilities experience higher rates of domestic violence but are not commonly found in domestic violence services. Missing in this thesis is how women with disabilities change their situations and get out of abusive environments given their dependence and high levels of social isolation. Milberger et al., assumed that 89% of the women who reported that their abuse occurred in the past were able to change their situation, getting themselves out of abusive situations by using their own resilience and personal strengths.[184] This assumption contradicts their own findings that since this group is dependent and isolated and lacks of social supports, it is impossible to change their own situations without formal supports. Research concerning where, if anywhere, women with disabilities access services and how their disability status influences this process are currently being explored. The answers to these questions will uncover the types of services that are relevant in addressing domestic violence of this highly invisible and vulnerable group.

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and Dean G. Kilpatrick. "Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study." (*American Journal of Public Health*, 2010).

184   Sharon Milberger, Nathaniel Israel, Barbara LeRoy, Angela Martin, Linda Potter and Pam Patchak-Schuster. "Violence Against Women with Physical Disabilities." (*Violence and Victims,* 2003).

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