Abuse and Women with Disabilities

Margaret A. Nosek and Carol A. Howland

Defining Disability and Abuse

For the purpose of this paper, the term disability will encompass the following impairments: disability that can increase vulnerability to abuse resulting from physical, sensory, or mental impairments, or a combination of impairments; physical disability resulting from injury (e.g., spinal cord injury, amputation), chronic disease (e.g., multiple sclerosis, rheumatoid arthritis), or congenital conditions (e.g., cerebral palsy, muscular dystrophy); sensory impairments consisting of hearing or visual impairments; and mental impairments comprising developmental conditions (e.g., mental retardation), cognitive impairment (e.g., traumatic brain injury), or mental illness.

Emotional abuse is being threatened, terrorized, severely rejected, isolated, ignored, or verbally attacked. Physical abuse is any form of violence against one's body, such as being hit, kicked, restrained, or deprived of food or water. Sexual abuse is being forced, threatened, or deceived into sexual activities ranging from looking or touching to intercourse or rape.

Prevalence of Violence Against Women with Disabilities

The prevalence of abuse among women in general has been fairly well documented, yet only a few North American studies (review by Sobsey, Wells, Lucardie, & Mansell, 1995), primarily from Canada, have examined the prevalence among women with disabilities.

The Disabled Women's Network of Canada (Ridington, 1989) surveyed 245 women with disabilities and found that 40% had experienced abuse; 12% had been raped. Perpetrators of the abuse were primarily spouses and ex-spouses (37%) and strangers (28%), followed by parents (15%), service providers (10%), and dates (7%). Less than half these experiences were reported, due mostly to fear and dependency. Ten percent of the women had used shelters or other services, 15% reported that no services were available or they were unsuccessful in their attempts to obtain services, and 55% had not tried to get services.

Sobsey and Doe (1991) conducted a study of 166 abuse cases handled by the University of Alberta's Sexual Abuse and Disability Project. The sample was 82% women and 70% persons with intellectual impairments, and covered a very wide age range (18 months to 57 years). In 96% of the cases, the perpetrator was known to the victim; 44% of the perpetrators were service providers. Seventy-nine percent of the individuals were victimized more than once. Treatment services were either inadequate or not offered in 73% of the cases.

The Ontario Ministry of Community and Social Services (*Toronto Star*, April 1, 1987) surveyed 62 women and found that more of the women with disabilities had been battered as adults compared to the women without disabilities (33% versus 22%), but fewer had been sexually assaulted as adults (23% versus 31%).

An extensive assessment of the sexuality of noninstitutionalized women with disabilities, which included comprehensive assessment of emotional, physical, and sexual abuse, was conducted by the Center for Research on Women with Disabilities (CROWD) through a grant from the U.S. National Institutes of Health. This study also covered other areas that may

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be associated with abuse, such as sexual functioning, reproductive health care, dating, marriage, parenting issues, and the woman's sense of self as a sexual person. The design of the study consisted of (1) qualitative interviews with 31 women with disabilities, and (2) a national survey of 946 women, 504 of whom had physical disabilities and 442 who did not have disabilities. Disabilities reported most frequently included spinal cord injury, cerebral palsy, muscular dystrophy, multiple sclerosis, and joint and connective tissue diseases.

Abuse issues emerged as a major theme among the 31 women interviewed in the first phase of this study. An analysis of reports of abuse in those interviews was described by Nosek (1996). Twenty-five of the 31 women reported being abused in some way. Of 55 separate abusive experiences, 15 were reported as sexual abuse, 17 were physical (nonsexual) abuse, and 23 were emotional abuse.

The findings from the qualitative study were used to develop items for the national survey. Two pages of the 51-page survey were devoted to abuse issues, encompassing more than 80 variables, including type of abuse by perpetrator and age when abuse began and ended, plus two open-ended questions. Analyses of these data (Young, Nosek, Howland, Chanpong, & Rintala, 1997) have revealed that abuse prevalence (including emotional, physical and sexual abuse) was the same (62%) for women with and without disabilities. There were no significant differences between percentages of women with and without disabilities who reported experiencing emotional abuse (52% versus 48%), physical abuse (36% in both groups), or sexual abuse (40% versus 37%). The most common perpetrators of emotional and physical abuse for both groups were husbands, followed by mothers, then fathers. Emotional abuse by husbands was reported by 26% of all women in both groups; physical abuse by husbands was reported by 17% of all women with disabilities and 19% of all women without disabilities. The most common perpetrator of sexual abuse was a stranger, as reported by 11% of women with disabilities and 12% of women without disabilities. Women with disabilities were significantly more likely to experience emotional and sexual abuse by attendants and health care workers. Women with disabilities reported significantly longer durations of physical or sexual abuse compared to women without disabilities (3.9 years versus 2.5 years). In an analysis of sexual functioning, abuse was found to be a significant predictor of lower levels of satisfaction with sex life among women with disabilities (Nosek, Rintala, Young, Howland, Foley, Rossi, & Chanpong, 1995)

Others have reported a history of sexual abuse among 25% of adolescent girls with mental retardation (Chamberlain, Rauh, Passer, McGrath, & Burket, 1984), 31% of those with congenital physical disabilities (Brown, 1988), 36% of multihandicapped children admitted to a psychiatric hospital (Ammerman, Van Hasselt, Hersen, McGonigle, & Lubetsky, 1989), and 50% of women blind from birth (Welbourne, Lipschitz, Selvin, & Green, 1983). In spite of these high percentages, few women receive treatment from victim services specialists (Andrews & Veronen, 1993).

Abuse Interventions for Women with Disabilities

There have been virtually no studies that examine the existence, feasibility, or effectiveness of abuse interventions for women with disabilities. In both the disability rights movement and the battered women's movement, it is generally acknowledged that programs to assist abused women are often architecturally inaccessible, lack interpreter services for deaf women, and are not able to accommodate women who need assistance with daily self-care or medications (Nosek, M.A., Howland, C.A., & Young, M.E. 1998). Merkin and Smith (1995), in discussing the needs of deaf women, state that counseling is more effective when sensitive to deaf culture issues and appropriate communication techniques.

Crisis interventions typically include escaping temporarily to a woman's shelter, having an escape plan ready in the event of imminent violence if the woman chooses to remain with the perpetrator, and escaping permanently from the abuser. These options may be problematic for the woman with a disability if the shelter is inaccessible or unable to meet her needs for personal assistance with activities of daily living, if the shelter staff are unable to communicate with a deaf or

speech-impaired woman, if she depends primarily on the abuser for assistance with personal needs and has no family or friends to stay with, or if she is physically incapable of executing the tasks necessary to implement an escape plan such as packing necessities, hiding money, and driving or arranging transportation to a shelter or friend's home.

Andrews and Veronen (1993) list four requirements for effective victim services for women with disabilities. First, service providers need to provide adequate assessment of survivors, including questions about disability-related issues. Second, abuse service providers should be trained to recognize and effectively respond to needs related to the disability, and disability service providers should be trained in recognizing and responding to physical and sexual trauma. Third, barriers to services should be eliminated by providing barrier-free information and referral services, by ensuring physical accessibility to facilities, by providing 24-hour access to transportation, to interpreters, and to communication assistance, and by providing trained personnel to monitor risks and respond to victims receiving services through disability programs. Finally, persons with disabilities who are dependent on caregivers, either at home or in institutions, may need special legal protection against abuse.

The National Domestic Violence Hotline keeps a database of battered women's shelters throughout the country, with indications of their architectural accessibility and the availability of interpreter services. Although the hotline is equipped with telecommunication devices for persons who are deaf, it is rarely used. The National Coalition Against Domestic Violence has issued a manual that gives specific guidelines for battered women's programs on implementing accessibility modifications according to the requirements of the Americans with Disabilities Act and increasing sensitivity and responsiveness among program staff to the needs of abused women with disabilities (National Coalition Against Domestic Violence, 1996).

Critique of Studies on Abuse and Disability

Until recently, the problem of abuse among people with disabilities has received very little attention. Early studies suffered from many methodological weaknesses. Essential constructs and variables important to statistical analysis were rarely defined. There was a particular lack of distinction among emotional, physical, and sexual abuse.The studies used unstandardized measurement instruments and techniques. Global references were made to the type of abuse, for example, emotional versus sexual; however, there was little attempt to document or categorize specific incidents by perpetrator. Samples in these studies were generally quite heterogeneous in terms of disability type, gender, and age. There was also the use of convenience sampling, such as using clients of intervention programs or police reports, as opposed to representative or random sampling. Statistical analyses rarely go beyond frequencies and measures of central tendency. Due to the heterogeneity of the samples, analyzing specific experiences of individuals with specific characteristics (such as sexual abuse among adult women with mental illness) would result in subsamples too small to allow the use of more sophisticated analytic procedures.

The recent study by the Center for Research on Women with Disabilities addressed a number of these issues. It had clearly defined variables; assessed types of abuse, perpetrator, and duration of abuse; sampled a broad range of women nationwide, including an able-bodied comparison group; and was restricted to a defined sample of adult women with physical disability. The issue of designing and implementing appropriate intervention studies for women with disabilities has received no attention beyond observation and speculation.

Conclusion

There is no question that abuse of women with disabilities is a problem of epidemic proportions that is only beginning to attract the attention of researchers, service providers, and funding agencies. The gaps in the literature are enormous. For each disability type, different dynamics of abuse come into play. For women with physical disabilities, limitations in physically escaping violent situations are in sharp contrast to women with hearing impairments, who may be able to escape but face communication barriers in

most settings designed to help battered women. Certaincommonalities exist across disability groups, such as economic dependence, social isolation, and the whittling away of self-esteem on the basis of disability as a precursor to abuse. Research that employs methodologic rigor must be conducted with women who have disabilities such as blindness, deafness, mental illness, and mental retardation. Particular attention must be paid to identifying vulnerability factors that are disability-related as opposed to those factors experienced by all women.

We must know more about interventions that are effective for women with disabilities. Considerable work has been done in this area for women in general; however, many of the recommended strategies are not feasible for women with disabilities. Few of the strategies listed in classic safety plans are possible for women who must depend on their abuser to get them out of bed in the morning, dress them, and feed them. There are only a handful of programs across the country that specifically address the needs of abused women with disabilities, making controlled intervention studies very difficult.

Much more work must be done to increase the awareness of providers of disability-related services so that they can recognize abuse among their clients and make appropriate referrals to battered women's programs. Correspondingly, much more work must be done to increase the capacity of battered women's programs to serve women with all types of disabilities.

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References

Ammerman, R. T., Van Hasselt, V. B., Hersen, M., McGonigle, J. J., & Lubetsky, M. J. (1989). Abuse and neglect in psychiatrically hospitalized multihandicapped children. *Child Abuse & Neglect, 13,* 335-343.

Andrews, A. B., & Veronen, L. J. (1993). Sexual assault and people with disabilities. Special issue: Sexuality and disabilities: A guide for human service practitioners. *Journal of Social Work and Human Sexuality, 8*(2), 137-159.

Asch, A., & Fine, M. (1988). Introduction: Beyond Pedestals. In: Fine, M., & Asch, A. (Eds.) *Women with disabilities: Essays in psychology, culture, and politics.* Philadelphia, PA: Temple University Press.

Brown, D. E. (1988). Factors affecting psychosexual development of adults with congenital physical disabilities. *Physical and Occupational Therapy in Pediatrics, 8*(2-3), 43-58.

Chamberlain, A., Rauh, J., Passer, A., McGrath, M., & Burket, R. (1984). Issues in fertility control for mentally retarded female adolescents I: Sexual activity, sexual abuse, and contraception. *Pediatrics, 73,* 445-450.

Merkin, L., & Smith, M. J. (1995). A community based model providing services for deaf and deaf-blind victims of sexual assault and domestic violence. *Sexuality and Disability, 13*(2), 97-106.

National Coalition Against Domestic Violence. (1996). *Open minds, open doors: Technical assistance manual assisting domestic violence service providers to become physically and attitudinally accessible to women with disabilities.* Denver, CO: National Coalition Against Domestic Violence.

Nosek, M.A. (1996). Sexual abuse of women with physical disabilities. In D. M. Krotoski, M. A. Nosek, & M. A. Turk (Eds.), *Women with physical disabilities: Achieving and maintaining health and well-being*. (pp. 153-173). Baltimore, MD: Paul H. Brookes.

Ontario Ministry of Community and Social Services. (1987). Disabled women more likely to be battered, survey suggests. *The Toronto Star, April 1*, F9

Ridington, J. (1989). *Beating the "odds":Violence and women with disabilities (Position Paper 2).* Vancouver: DisAbled Women's Network: Canada.

Sobsey, D., Wells, D., Lucardie, R., & Mansell, S. (Eds.) (1995). *Violence and disability: An annotated bibliography.* Baltimore, MD: Paul H. Brookes.

Sobsey, D., & Doe, T. (1991). Patterns of sexual abuse and assault. *Sexuality and Disability, 9*(3), 243-260.

Welbourne, A., Lipschitz, S., Selvin, H., & Green, R. (1983). A comparison of the sexual learning experiences of visually impaired and sighted women. *Journal of Visual Impairment and Blindness, 77,* 256-259.

Young, M.E., Nosek, M.A., Howland, C.A., Chanpong, G., Rintala, D.H: (1997) Prevalence of abuse of women with physical disabilities. *Archives of Physical Medicine and Rehabilitation Special Issue.* 78 (12, Suppl. 5) S34-S38

In Brief:
Abuse and Women with Disabilities

Prevalence of Abuse among Women with Disabilities

·Sixty-two percent of a national sample of women with physical disabilities reported having experienced emotional, physical, or sexual abuse. The same percentage of a comparison group of women without disabilities reported abuse, but the women with disabilities had experienced abuse for longer periods of time.
·The most common perpetrators of abuse were husbands and parents for both women with and without disabilities. Women with disabilities, however, were significantly more likely to experience emotional and sexual abuse by attendants and health care workers.
·In addition to the types of abuse experienced by all women, women with physical disabilities are sometimes abused by withholding needed orthotic equipment (wheelchairs, braces), medications, transportation, or essential assistance with personal tasks, such as dressing or getting out of bed.
·Others have reported a history of sexual abuse among 25% of adolescent girls with mental retardation, 31% of those with congenital physical disabilities, 36% of multihandicapped children admitted to a psychiatric hospital, and 50% of women blind from birth.

Interventions for Abused Women with Disabilities

·There have been no studies that examine the existence, feasibility, or effectiveness of abuse interventions for women with disabilities.
·Women with disabilities face serious barriers to accessing existing programs to help women remove violence from their lives. In both the disability rights movement and the battered women's movement, it is generally acknowledged that programs to assist abused women are often architectually inaccessible, lack interpreter services for deaf women, and are unable to assist women who need assistance with daily self care or medications.

Recommendations for Research and Program Development

·Provide, or refer to, legal assistance for obtaining restraining orders and managing court systems which is accessible to women with disabilities.
·Keep statistics on the number of women with disabilities who call crisis hot line / use other program services.
·Assist and encourage police in recording disability status in their crime reports, as well as encouraging adoption of a separate category for perpetrators who are caregivers.
·Offer training to disability-related service providers, including independent living centers and churches, on recognizing the symptoms of abuse and the characteristics of potential batterers. They should be familiar with, and able to refer to, resources for battered women in their community.
·Train staff on how to communicate with persons who have hearing, cognitive, speech, or psychiatric impairments. They should understand environmental barriers faced by women with physical and sensory disabilities when offering advice or referrals for obtaining shelter.
·Have on hand an extensive network of community referrals and contact numbers, including volunteers or other community resources for obtaining personal assistance.

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