Module I:

- Overview and Scope of the Problem
- Risk Factors for Domestic Violence and Sexual Assault
- Expanding Definitions of Abuse and Assault
- Service Challenges
Presenter Instructions:

1. Introduction to domestic violence, sexual assault, and disability (15 minutes)
   
   • This activity will provide an overview of disability and the problem of domestic violence and sexual assault among people with disabilities.
   
   • Specific training on these topics is necessary to better understand the needs and build programs that serve survivors with disabilities who have often been isolated and underserved.
   
   • Staff training is offered as part of an ongoing agency commitment to improve capacity to meet the unique needs of survivors with various disabilities and future training will be provided.
   
   • To understand the unique issues facing survivors with disabilities, we will examine and discuss the following questions:

   Who are people with disabilities?
   What is the experience of being disabled and a woman?
   What do we know about race and disability?
   How big is the problem of violence among disabled people?
   How is the experience of violence unique for survivors with disabilities?

   • There are approximately 54 million Americans with Disabilities (US Department of Justice, Crime Victim Bulletin, 1998) and about half of these persons have severe disabilities, meaning they need some form of assistance with activities of daily living (Census, 2000).

   • Approximately 3.5 % of the population has a mental health disability with 15% having a physical disability (InfoUse, 2004).

   • According to the US Census, there are approximately 4 million people with Developmental Disabilities in the US, and the Massachusetts Department of Mental Retardation sites 394,978 people with mental retardation in Massachusetts (DMR, 2004).

   • Disability rates vary by race from a low of 9.9% for Asian and Pacific Islanders to a high of 21.9% for Native Americans. Asian and Pacific Islanders have the lowest percentages of severe disability (4.9%). Blacks have the highest proportion of those with a severe disability (12.2%) (InfoUse, 2004).
• The 1996 *Chartbook on Disability* reports that approximately 41 million white persons have a disability, with 19.7 million of those being severely disabled. An estimated 6.3 million blacks report a disability, with 3.8 million of those having a severe disability. An estimated 361,000 American Indians, Eskimos, or Aleuts report a disability, with 162,000 being severe. Asian Americans report 777,000 people with a disability and 384,000 with a severe disability. Of those with a Hispanic origin (who can be of any race), 3.4 million reported a disability and 1.8 million reported a severe disability (InfoUse, 2004).

• Definitions of disability vary, making identification of this population and understanding the problem of violence challenging.

• Women with disabilities are a unique population, often devalued by society on the basis of both gender and disability.

• Understanding the experiences of violence and abuse for women with disabilities is a complex task. Invisibility and social perceptions of women with disabilities as asexual or overly sexual, and isolation contribute to the lack of knowledge about survivors with disabilities.

• Women with disabilities experience social and economic discrimination that results in isolation and economic disadvantage. Many women with disabilities, especially older women, live in poverty. According the Disability Statistics project at Cornell University, the unemployment rate for people with disabilities was about 14%, three times higher than the unemployment rate of 5.8% among people without disabilities in 2003 (www.cornell.org).

• Women with cognitive and psychiatric disabilities face unique risks of abuse, due to exposure to multiple caretakers, professionals, and institutionalization. Such abuse can be hard to identify and is under-reported.

• Both the disability rights movement and the feminist movement have largely overlooked the unique issues women with disabilities face, and thus lack understanding of the magnitude of the problem of sexual assault and domestic violence.

• Most importantly, women with disabilities are women who simply want to live fulfilling lives like other women. They are daughters, sisters, mothers, and grandmothers. They are friends, lovers, wives, and partners who nurture others and raise families. They are professionals and workers of all kinds. A large percentage of women with disabilities are older women who may also face age discrimination.

Data provided above was obtained from US Census Bureau reports and online from *The Chartbook on Disability* available at www.infouse.org.

2. **Review of disability and violence statistics (15 minutes)**

Use the following narrative to review statistics that help to shape an understanding of the problem of domestic violence, sexual assault, and disability. Ask participants to note and comment on the interconnections between disability, domestic violence, and sexual assault. Copy and distribute the narrative and references if desired.
• Violence against women with disabilities is a multi-dimensional problem influenced by a range of individual, societal, and economic factors. Women with disabilities experience stigma, discrimination, segregation, dehumanization, and disenfranchisement both for being women and for being disabled (Fine & Asch, 1998). Additional dimensions of identity, such as race or sexual orientation, compound the experience of disability and gender-based oppression with little information available to adequately illuminate these issues. Oppressive social and economic factors result in the low self-esteem, poverty, isolation, unnecessary dependence, and lack of support services that contribute to the vulnerability of women with disabilities to assault and abuse and limit options for leaving abusive situations.

• Studies indicate that women with disabilities experience violence at higher rates than non-disabled women. Among women 18 – 59, women with disabilities were twice as likely to have experienced intimate partner abuse in the past year compared to women without disabilities (MDPH – BRFSS, 2001). Women with disabilities were also more likely to have experienced sexual assault i.e., unwanted sexual contact (34%) compared to women without disabilities (18%) (MDPH – BRFSS, 2001). Among people with disabilities who have been sexually assaulted, 82% are female (Sobsey, 1994). Estimates show that children and adults with disabilities are two times more likely to experience abuse than their non-disabled peers, and those rates are higher when individuals are exposed to multiple perpetrators. In one study, 79.6% of people with disabilities were assaulted on more than one occasion, and 50% of those experienced ten or more victimizations. The victims knew the perpetrator in 92% of the cases, which included family, caretakers, and health professionals (Sobsey & Doe, 1991). It is estimated that caregivers commit at least 25% of the sexual assaults against individuals with disabilities (Berkeley Planning Associates, 1997).

• Women with disabilities experience many unique forms of violence and assaults such as withholding or forcing medication, withholding food or medical treatment, damage or destruction of adaptive equipment, control of money/benefits, extreme isolation, and often more severe violence, calculated to injure, control, and humiliate the victim (Masuda, 1996). Additionally, the violence experienced by people with disabilities is more severe and prolonged, and the effects more serious and long lasting (Tyskia, 1998).

• Uniquely vulnerable, people with developmental disabilities experience very high rates of sexual assault. Some studies have found that approximately 90% of men and women with developmental disabilities will experience sexual abuse at some point in their lives (Valenti-Hein & Schwartz, 1995). A national study found that between 39-83% of females and 16-32% of males with developmental disabilities will be sexually abused before they reach 18 (Baladerian, 1995). In 2003, the Massachusetts Disabled Persons Protection Commission reported that 5,773 abuse reports were made to the hotline. Of those reported allegations of abuse by a caretaker, 46% involved men and 54% involved women as targets of abuse (DPPC, 2003). These statistics demonstrate that while women are at higher risk, men are also targets.
• Abuse, neglect, and sexual assault are also significant causes of disability, particularly head injury and mental health disabilities. In a study of 100 psychiatric patients, 81% had been sexually assaulted in their lifetime. Childhood sexual assault is considered a strong predictor of later psychiatric disability (Jacobson and Richardson, 1997). In one study, abuse led to or caused disabilities in 62% of girls who were sexually assaulted, 48% who were emotionally abused, and 55% who were neglected (Crosse, et al 1993).

• Many women with disabilities who are sexually assaulted or victims of domestic violence do not receive treatment. Barriers to receiving services include lack of education, lack of accessible services and shelters, lack of community supports for reporting abuse and sexual assault, and discrimination in the criminal justice system. One study showed that up to 90% of women with disabilities did not receive treatment and the numbers were highest among institutionalized populations who were also the least likely to report abuse (Balderian, 1991). According to a 1999 report by the Massachusetts Department of Public Health, disabled survivors of sexual assault were less likely to report sexual assault to the police than non-disabled women. Most women with disabilities who did report, reported abuse to a social service agency, hospital, or physician (MDPH – BRFSS, 1997-1999).

3. Discussion (15 minutes)

➢ Ask participants to discuss connections between disability, sexual assault, and domestic violence.
➢ How does the information presented confirm or contradict your knowledge or perceptions of the problem?
➢ What was your overall reaction to hearing these statistics about domestic violence, sexual assault, and disability?
➢ How do race and other identities affect the experience of violence and disability?
➢ What information is missing? What would you like to know?
➢ What can we do to learn more about this problem and to support the collection of relevant data?
**Topic:** Risk Factors for Domestic Violence and Sexual Assault

**Goal:** Familiarize participants with unique constellation of risk factors for abuse and sexual assault as they affect women with disabilities.

**Time:** 60 minutes  
**Materials:** None  
**Preparation:** None

**Presenter Instructions:**

1. **Present risk factors for violence against people with disabilities (10 minutes)**
   - Women with disabilities experience many of the same risks of violence as other women. However, they experience some additional unique risks.
   - Women with disabilities are easier targets for abuse and sexual assault as they may be more socially isolated because of their disability, the inaccessibility of communities, and dependence on others for their care.
   - Women with cognitive or psychiatric disabilities, particularly those who are institutionalized, face unique risks for caretaker and professional abuse.
   - Negative attitudes toward women and men with disabilities can lead to hatred and dehumanization that foster violence against them and also result in discriminatory practices in violence prevention, treatment, and law enforcement.

2. **Discuss societal perceptions and reactions that contribute to increased risk of violence toward women with disabilities and the effects of exposure to violence (30 minutes)**
   - **Sexually unrealistic perceptions by society:** Women with disabilities are often viewed as completely asexual, physically or sexually undesirable, incapable of relationships, and not able to engage in sexual acts. Women with psychiatric disabilities may be stereotyped as overly sexual or sexually dangerous. They may also be characterized as asexual. Eroticizing vulnerability and sexual objectification of certain types of disabilities dehumanize women with disabilities and make them easier targets.
   - **Perceived as vulnerable, treated as incapable:** Women with disabilities are often raised in overly protected or isolated environments where lack of social exposure and interaction contribute to learned helplessness and self-perceptions of vulnerability. Lack of social interaction fosters misunderstanding of appropriate social roles and expectations, deepens isolation and feelings of helplessness, and encourages compliance with those exerting power or authority.
   - **Limited access to information:** Isolation and protectiveness limit access to information about healthy social and sexual interactions. Women with some disabilities may not learn the skills necessary for communicating about sex, sexual
desires, and boundaries. Women who are disabled may have difficulty accessing information due to communication barriers. Women with disabilities lack opportunities to come to know themselves sexually and are often discouraged from expressing desires. Women with developmental disabilities, head injuries, or severe psychiatric disability may not fully understand sexual acts and their consequences.

- **Multiple assaults:** Women with disabilities who have a history of child abuse or prior sexual assault may be vulnerable to further abuse and assault due to adult mental health problems of depression, low self-esteem, feelings of fear and helplessness, confusion about intimacy, or lack of understanding about appropriate sexual boundaries.

- **Exposure to multiple caretakers:** Women with disabilities who are dependent on others for physical care or who are institutionalized are exposed to many different caretakers during the course of their lives. Dependence and the isolation of institutions add to the risk of sexual assault and abuse.

- **Lack of role models:** Isolation limits interaction with other women with disabilities. Most children with disabilities are raised by non-disabled parents and lack contact with adults with disabilities. Adult women with disabilities, particularly those with cognitive or psychiatric disabilities, have few images of disabled women in healthy social or sexual relationships.

- **Internalized oppression and low self-esteem:** Women with disabilities may remain in unhealthy relationships and live with uncomfortable or unsafe sexual experiences believing these may be their only options for sexual contact. They may experience sexual involvement as a way to be “normal.”

- **Lack of skills in self-protection:** Women with disabilities may be poorly prepared for dangerous situations, surprised when threatened, and ill-equipped to protect themselves (Schaller and Lagergren, 1998).

- **History of mistreatment by systems and professionals:** Many adults and children with disabilities have previously experienced pain and mistreatment at the hands of the medical system, the mental health system, and individual professionals such as therapists. In medical, rehabilitative, and institutional settings individuals lose the right to make their own decisions, are taught to be compliant, have little or no privacy, face objectification of their body parts, and experience an atmosphere of sickness rather than healing that can lead to negative self-perceptions. People who have been abused in this way may distrust systems and professionals and not reach out for help when they are being abused.

3. Discussion (20 minutes)

- Ask participants to get into pairs or small groups. Have participants identify any additional risks and discuss comments or questions about the information presented.
- Ask the full group to reflect on the following question: How have you observed these perceptions in our society and how might they impact your work with survivors?
Consider a role-play that illuminates the dynamics of learned helplessness by having the trainer play the role of client and participants try to assist an individual who is passive or has been taught to be compliant. What are the challenges of serving and helping to empower this individual? How can learned helplessness be confronted without blaming or shaming the survivor for what has happened?
Presenter Instructions:

1. Present on contributing factors in the abuse of people with disabilities (10 minutes)

- Women with disabilities are subject to many of the same forms of abuse as other women along with unique types of abuse. Abuse is also often easier to hide by perpetrators and ignored or misunderstood by professionals.
- Some abuse may be facilitated by the intimate and private nature of care-taking relationships at home or in institutional settings. These opportunities for intimacy and the dependency that comes with needing assistance with activities of daily living, such as bathing, feeding, meal preparation, dressing, and menstrual care, create unique opportunities for abuse. Emotional abuse of a dependent person is also a common experience.
- The power dynamics and stress involved in economic and physical dependency on family or spouses often contribute to family stress, personal feelings of being a burden, and other conditions that foster abuse, but should never be viewed as reason to excuse abuse or neglect.
- Women with cognitive and psychiatric disabilities are at risk of physical and emotional abuse and sexual assault associated with therapeutic professionals and during stays in institutional facilities. Women who are deemed incompetent or who are committed to a residential or inpatient facility can be uniquely captive to abusers with few options to complain or escape. This type of abuse and assault may be difficult to identify and is under-reported.
- Negative attitudes that devalue people with disabilities and difficulty prosecuting perpetrators has contributed to lack of responsiveness on the part of law enforcement and an ineffective criminal justice system which lets many crimes go unpunished. Perpetrators get the message that they can get away with abuse or assault.

2. Review types of abuse for people with disabilities (10 minutes)

Use the list for presentation and as a handout. The following list is adapted from a list prepared by the Massachusetts Disabled Persons Protection Commission (MDPPC) that identifies some of the unique ways that disabled women are abused. Many of the items
listed reflect physical abuse, but emotional abuse is also a serious problem. In addition, women with cognitive, psychiatric, and communication disabilities are particularly vulnerable to abuse that involves placing limitations on decision-making.

**Types of Abuse**
- Withholding medication or over-medicating
- Withholding personal care or assistance
- Withholding needed medical equipment such as walkers, canes, wheelchairs
- Rough handling such as causing physical pain during routine dressing or bathing (i.e. yanking the person’s arms to cause pain while taking off the individual’s shirt or dropping the person while transferring them in and out of the tub)
- Refusing to fix meals or feed the person
- Making the individual lie in her own waste or remain unwashed/unbathed
- Withholding benefits/money or controlling the person’s finances/making purchases
- Identity fraud
- Making decisions, misrepresenting a person’s wishes, or acting in place of an individual
- Restricting movement outside the home or residential facility
- Withholding access to communication such as interpreters and TTY
- Limiting choices around reproduction and sexual expression, i.e. forced sterilization/abortion/birth control
- Emotional abuse related to disability – disability insults, teaching people not to trust their perceptions and judgments, and undermining self-confidence

3. **Review signs of abuse (20 minutes)**

Use lists for presentation and as handouts. Explain that in addition to looking at types of abuse, it is important to recognize signs of abuse and neglect, which are unique or more common to a woman with a disability. The following is a partial list of indicators adapted from a list prepared by the Disabled Persons Protection Commission and from interviews with survivors. Additional information is available at DPPC’s website: [http://www.state.ma.us/dppc](http://www.state.ma.us/dppc).

**Injuries/Illness/Behavior of Survivors:**
- Bruises and/or welts: bilateral bruising, bruises in the shape of familiar objects like belt buckles or hand prints, multiple bruising, bruises that are hidden under braces, other orthotics, elastic stockings, phony bandages, etc.
- Burns: scalding burns, burns in the shape of cigarettes or cigars, burns in the shape of familiar objects like irons. Braces, bandages, or orthotics may also hide burns.
- Abrasions: scratches from fingernails, marks from ropes or other restraints.
- Open wounds: cuts, lacerations, punctures, or wounds, particularly bed sores or sores under braces, bandages, or orthotic devices.
Musculoskeletal injuries: sprains, dislocations, fractures or broken bones.
Internal injuries: unexplained pain, difficulties with normal functioning of organs.
Sexual abuse: genital pain or itching, vaginal or anal irritation or bleeding, or bruises on external genitalia, vaginal or anal areas.
Sick, vomiting, or groggy, possibly from medications, lack of food, or toxic substances.
Emotional changes: Depression, self-injury, suicidal ideation, anxious, fearful, aggressive, confused, or other unusual displays of emotions.

Neglectful Conditions
- Condition of the person: unclothed, poorly clothed for weather, poor hygiene, dehydrated, malnourished, bedsores, lack of needed medical equipment.
- Condition of environment: inadequate food or food storage, no toilet or commode, fire hazards, no phones or outside access, inadequate ventilation, heating or cooling, restraining devices evident, etc.
- Social conditions: isolated, lack of access to communication, money, transportation, and information about rights.

Behavior of Caregivers/Abusers
- Speaks for the person.
- Leaves a dependent individual unattended or alone for long periods of time.
- Does not show up to provide care or delays care too long.
- Blames the person for injuries, bruises, or burns.
- Excuses injuries, bruises, burns as accidents that occurred due to the disability or in caring for the person. “She always gets bedsores because her skin is just so sensitive”; “She just tripped”; “I told her not to get into the tub without me there, no wonder she fell”; “She wanted to do it herself and that’s how she got burned”; “She is delusional, makes up stories all the time”; etc.
- Ignores or does not speak to the individual and emotionally isolates him/her.
- Fosters confusion, self-doubt, or fear.
- Does not touch or comfort person.
- Threatens to leave the person if they don’t behave according to perpetrator’s wishes.

4. Discussion (10 minutes)

- Ask participants if they were surprised by any of the items mentioned above and if they have any questions, comments, or something to add to the lists.
- Give the list above to participants as a handout. Ask participants to individually review the list and indicate on the handout whether each type of abuse is the same or different as what is experienced by survivors without disabilities. Then discuss either in small groups or as a large group.
Topic: Service Challenges

Goal: Familiarize participants with the problems of domestic violence and sexual assault as they affect women with disabilities.

Time: 60 minutes
Materials: Newsprint and markers
Preparation: None

Presenter Instructions:

1. Present about barriers to serving women with disabilities (30 minutes)

Present about the various problems that exist in identifying abuse among survivors with disabilities as well as the challenges to making appropriate interventions.

- Survivors with disabilities may be abused in “non-typical” ways, such as the withholding of medications, lack of personal care, unique financial vulnerability, restriction of mobility, fostering confusion and helplessness, and disability-related insults.
- Survivors with disabilities may not recognize their treatment as abusive or may feel they “deserve” such treatment.
- Survivors with cognitive disabilities or severe psychiatric disability may not fully understand sexual acts or their consequences.
- Previous history of trauma can make it difficult for survivors with disabilities to take necessary actions to free themselves from abusive situations.
- Isolation and lack of information makes it difficult for survivors with disabilities to reach out for help and for professionals to detect abuse or follow up on interventions.
- Communication barriers can make it difficult for survivors who are Deaf or who have communication disorders to make contact with programs or police.
- Professionals can be abusers, leading to mistrust of other professionals trying to help.
- Survivors with disabilities may be physically and economically reliant on caretakers or family who are also abusive, making escape difficult.
- Many survivors with disabilities live in group residential facilities where they are uniquely vulnerable to professional and caretaker abuse. Exposure to multiple caretakers who are employed by the facility rather than the individual leave institutionalized persons hesitant to report abuse by people they fear will retaliate.
- Social attitudes and myths about the sexuality (or lack thereof) or promiscuity of women with disabilities place them at greater risk of assault and contribute to delays in getting help.
- Hotline counselors, shelter staff, and others in domestic violence and sexual assault programs do not always have adequate knowledge of disability, people with disabilities experiences, or the unique issues of abuse and sexual assault for survivors with disabilities.
Shelters, rape crisis centers, and related domestic violence services often lack physical or communication access or have rules that unnecessarily exclude women with disabilities.

Shelters and rape crisis centers may not have adequate policies and sufficient staffing in place to manage disability needs such as medications, emotional crisis, personal care, or other complex issues.

Shelter and rape crisis center staff are not fully knowledgeable about long-term housing options or available community support that meets the unique needs of survivors with disabilities.

Abuse recovery models are often not flexible enough to meet the needs of survivors who cannot leave home.

Medical response to sexual assault and domestic violence has not adequately met the needs of survivors with disabilities.

Health care providers don’t always ask about abuse and often do not notice unique signs in survivors with disabilities.

Institutions and systems of care for people with disabilities are slow to respond to reports of abuse.

Disability organizations lack knowledge of the risks and signs of abuse as well as appropriate referrals.

Courts have viewed some survivors with disabilities as “unreliable,” so that reports of abuse or sexual assault may be dismissed. Survivors with cognitive or mental health disabilities are uniquely vulnerable in the court system.

Women with disabilities may risk losing their children in a court system that may view them as incapable parents.

Survivors with disabilities risk forced institutionalization if they are viewed as incompetent or incapable of caring for themselves.

Lack of community-based resources and supports, such as personal care attendants, transportation, and peer support programs, makes it difficult to help survivors with disabilities become independent and maintain their safety.

2. Opportunities for change (15 minutes)

Explain to participants that steps can be taken to address the issue of violence against women with disabilities and improve services to survivors with disabilities. Some of the changes are concrete and could be implemented immediately while others require long term systemic or agency change.

- Increase the comfort and knowledge base among persons working in the field of sexual assault and domestic violence about survivors with disabilities and their needs.
- Identify methods of detecting and intervening in abusive situations that respond to the unique needs of survivors with disabilities and their families.
- Increase physical and communication access to shelters, transitional supports, and sexual assault programs.
- Review and modify policies, procedures, staffing patterns and qualifications, and offer training as needed at shelters, rape crisis centers and related domestic violence services to adequately serve survivors with various disabilities, i.e. policy and procedures for handling medications, allowances for personal care attendants, adding staff with disabilities, teaching staff basic sign language, etc.
- Develop and implement disability appropriate medical protocols in response to abuse and sexual assault of women with disabilities.
- Advocate for increased community-based social supports that promote independence and personal safety.
- Conduct activities that empower women with disabilities to avoid abusive situations and maximize personal safety, while ensuring that responsibility to prevent abuse remains an institutional responsibility (e.g. avoid victim blaming).
- Educate professionals in many fields about the abuse of women with disabilities and how to respond.
- Develop collaborations with disability organizations to address the needs of individuals and communities.
- Change social attitudes that stereotype and discredit women with disabilities as well as limit their independence and potential.
- Work with the court system to increase awareness and improve treatment of survivors with disabilities.

3. Discussion (15 minutes)

- Ask participants for comments or questions on the information presented.
- What other challenges exist for sexual assault and domestic violence programs in reaching and serving survivors with disabilities? Write additions on newsprint and add to the list above for future reference.
- What concrete steps can sexual assault and domestic violence programs take to meet the needs of survivors with disabilities? Make a list.