Interpersonal Violence and Women With Disabilities: A Research Update

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Nosek and Howland's Applied Research document (1998) provided a snapshot of the first generation of research related to abuse and women with disabilities, documenting the seriousness of the problem and lack of accessible domestic violence services. This research, conducted in the late 1980s and 1990s, led to a second generation of studies in the current decade that have further defined the problem and deepened our understanding of barriers experienced by women with disabilities and Deaf women in promoting their safety from interpersonal violence. A consistent theme across the research is the complex intersections of Disabled and Deaf women's experience of impairment, poverty, isolation, reliance on others for support, discrimination, and other factors that may restrict women's violence awareness, safety promoting behavior, and access to resources (Copel, 2006; Hassouneh-Phillips, McNeff, Powers, & Curry, 2005; Nosek, Hughes, Taylor, & Taylor, 2006). Women's experience of their own status as women with disabilities and/or Deaf women may also influence their perspectives and response to interpersonal violence. This article provides an update on what researchers have learned during the past ten years about the scope of the problem and women's responses, and offers some perspectives on the state of current research and its implications for future studies and advocacy efforts.

People first language, such as "women with disabilities" is used in this article to emphasize the critical importance of understanding that people happen to experience disabilities that do not define them. In addition to using people first language, at some points we refer to women with disabilities as "Disabled women". This use of a capital "D" is deliberately meant to acknowledge the growing cultural identities of many people with disabilities, similar to the cultural identity being adopted by Deaf women, and reflecting the evolution of the meaning of disability from medical to cultural diversity. Our use of this terminology is intended to compliment rather than conflict with people first language. The capital "D" is used to specifically acknowledge Disabled individual's cultural identity and pride. While we use the terms "Disabled women" and "women with disabilities" in this article, we recognize that women with disabilities have diverse perspectives on the cultural meaning of disability and the language that is most appropriate. We deeply respect individuals with disabilities' personal choices regarding how they choose to identify and thank readers for considering both people first and cultural perspectives as they review this article.

Expanding the Scope of the Problem

While early research focused primarily on physical, sexual, and emotional violence against women with disabilities, additional forms of disability-specific violence have now been documented. Examples include destruction of medical equipment and communication devices, withholding, stealing or overdosing of medications, physical neglect, and financial abuse (e.g., Curry, Powers, Oschwald, & Saxton, 2004; Gilson, Depoy, & Cramer, 2001; McFarlane et al., 2001; Nosek, Foley, Hughes, & Howland, 2001a; Saxton et al., 2001). Recent

research continues to support earlier findings that maltreatment by personal assistants and other service providers is a unique problem facing Disabled women (Nannini, 2006; Nosek, Howland, Rintala, Young, & Chanpong, 2001c; Oktay & Tomkins, 2004; Powers et al., 2002; Saxton et al., 2006). This class of perpetrators includes not only spouses and other domestic partners who may dually function as unpaid or paid personal assistants but also parents or other family members, friends, and health care and other service providers. For this reason, the term interpersonal violence rather than domestic violence is used in this article. Dependence on a perpetrator for essential personal care and/or specialized services for communication or mobility (such as an interpreter or mobility guide) adds an additional layer of difficulty to seeking safety (Copel, 2006).

Recent studies confirm earlier findings that, compared to women without disabilities, women with disabilities are more likely to experience physical and sexual violence (Brownridge, 2006; Martin et al., 2006; Powers et al., 2002; Smith, 2008), increased severity of violence (Brownridge, 2006; Nannini, 2006; Nosek et al., 2001b), multiple forms of violence (Curry et al., 2004; Martin et al., 2006; Nosek et al., 2001a), and longer duration of violence (Nosek et al., 2001b). For example, Powers and colleagues (2002) surveyed 200 women with disabilities and found that 67% of the women had lifetime experiences of physical abuse and 53% had experienced lifetime sexual abuse. Brownridge (2006) found that, compared to women without disabilities, women with disabilities had a 40% greater chance of experiencing intimate partner violence in the five years prior to the study. Martin and colleagues (2006) found that women with disabilities were four times more likely to have experienced sexual assault in the past year than non-disabled women. In a recently completed study of 305 women with diverse disabilities and Deaf women, 68% of participants reported physical, sexual, emotional, and/or disability related violence in the past year (Curry et al., 2009, referred to as Safer and Stronger study). Likewise, preliminary

findings from 213 women with diverse disabilities enrolled in a study of an abuse and safety planning awareness program (ASAP for Women) reveal that many had experienced lifetime physical (65.9%) and sexual abuse (44.9%) (Hughes, Robinson-Whelen, Legerski, Gabrielli, & Lund, 2009).

Research consistently documents the high cost of interpersonal violence for women with disabilities, including its negative impact on women's abilities to work, to live independently, and to maintain their health (Hassouneh-Phillips et al., 2005; Nosek, Hughes, Swedlund, Taylor, & Swank, 2003; Nosek et al., 2006; Powers et al., 2002). In a survey conducted by Powers and colleagues (2002), of 200 women with mobility disabilities, and mobility and intellectual disabilities, 30% of the women reported that interpersonal violence kept them from maintaining employment, 61% said interpersonal violence stood in the way of independent living, and 64% indicated interpersonal violence kept them from caring for their health.

A few studies have identified factors that contribute to violence against Disabled women. Nosek and colleagues (2006) found that younger age, more education, less mobility, and higher levels of social isolation and depression were characteristics of 84% of the women who experienced interpersonal violence in the past year. The authors commented that this unusual finding, which associated abuse with more rather than less education, may have been a result of the study including a very highly educated group of participants. When Hughes and colleagues (2009) interviewed 14 women with physical disabilities who had resolved interpersonal violence, the participants identified several factors that contributed to the continuation of their abusive relationships. Those factors included problems with alcohol and other drugs, lack of education, untreated depression, and other mental health conditions. Brownridge (2006) examined the role of disability, victim, relationship, and perpetrator factors in intimate partner violence among 7,027 female participants in Canada's General Social Survey. Virtually all of the difference in violence rates between the women with and

without disabilities was accounted for by patriarchal domination and sexually proprietary behaviors by perpetrators. Likewise, Curry, et al. (2009) found that Disabled and Deaf women who had controlling perpetrators were more likely to experience multiple forms of abuse, compared to those women whose offenders had non-controlling characteristics.

Safety Promoting Behavior

Common barriers that keep women with disabilities from escaping interpersonal violence include embarrassment, not having a trusted person to talk with about abuse, not being believed, fear of losing independence or connections with family or friends if interpersonal violence is reported, and fear of retaliation (Curry et al., 2009; Powers et al., 2002; Saxton et al., 2001). Women who use personal assistance services have further identified the shortage of providers and low pay and benefits for providers as barriers to addressing violence by personal assistants. Lack of interpersonal violence education for Disabled women and their providers and lack of emergency back-up providers have also been identified as key obstacles to maintaining safety (Powers et al., 2002). Dependence on a perpetrator for assistance with eating and other essential activities of daily life also adds to the complexity of seeking safety (Copel, 2006; Curry et al., 2009). In comparison to women with non-intellectual disabilities, women with intellectual disabilities identify more barriers to reporting violence, such as fear of losing independence, past negative experiences in reporting, and perpetrator retaliation (Curry et al., 2009).

Only a small amount of information is available on safety promoting behaviors used by women with disabilities. Some writers focus on service utilization. For example, Nannini (2006) compared the sexual assault patterns of women with and without disabilities from 16,672 women survivors who sought services in Massachusetts from 1987 through 1995. Only about half as many women with disabilities (10.3%) sought services or disclosed disability at intake as would have been expected, given the estimated 20% of women with disabilities in the State. Of all the women who sought services, women with and without disabilities were equally likely to request the services themselves, except women with intellectual disabilities who often had others request services for them. A second study by Grossman and Lundy (2008) examined victim services data for approximately 44,000 individuals who sought rape crises services from 1998 through 2004. Survivors (85% female) were generally referred by social service agencies rather than self-referred. Only 2.5% of survivors in this sample were identified by the agencies as having a disability. Victims with disabilities received more hours of service overall and were more likely to receive individual, family and phone counseling, and medical and other advocacy. No differences were found between survivors with and without disabilities in their participation in criminal justice advocacy or group counseling. These findings on the use of victim's services should be interpreted with caution because they come from a small subset of women who were identified as having disabilities, an identification that could have been made because the women required additional services. Although domestic violence and sexual assault (DV/SA) programs are working to increase access to their services (e.g., Chang et al., 2003), research suggests that Disabled women are still largely underserved in these programs (Barile, 2002; Grossman & Lundy, 2008; Nannini, 2006; Nosek & Hughes, 2002).

A small number of studies have investigated Disabled women's self-reported use of safety promoting behaviors. Powers and colleagues' earlier survey (2002) asked women who used personal assistance to rate the importance of various strategies for preventing or stopping interpersonal violence by personal assistants (PAs). The most highly rated strategies were: (1) interpersonal violence awareness education, (2) increased access to resources, such as crisis lines, emergency transportation, shelters, and support groups, (3) assigning clear duties and setting limits with PAs, (4) being able to choose one's PA, and (5) having a back-up PA. Our recent *Safer and Stronger* study of the

safety promoting behaviors of women with disabilities and Deaf women (Powers et al., 2009) found than many of the women reported they had someone to talk to about interpersonal violence, they could recognize interpersonal violence, and they had taken steps to protect their money, keep their relationships safe and plan for emergencies. A majority of the women who used personal assistance reported they selected their personal assistants. Women who experienced multiple forms of abuse and those who had controlling perpetrators were more likely to have sought out information about interpersonal violence as well as restraining or stalking orders. These women were less likely to use assertive safety promoting behaviors, possibly because acting assertively would not be safe.

An overarching conclusion from this research is that Disabled and Deaf women's use of safety promoting behaviors is highly individualized and supports provided to these women, like those provided to women without disabilities, must take into account a variety of personal, perpetrator, and contextual issues. For example, when a survivor is Deaf or hard-of-hearing, certified or licensed ASL interpreters, or other support from people identified by the survivor must be provided during delivery of information, resources or counseling, including during any court services or procedures. Likewise, women with intellectual disabilities may require straightforward language formats, translation of print materials, supplemental pictures, and support from people who can communicate clearly with them.

Emerging Intervention Research

Because research on violence against women with disabilities was not initiated until the late 20th century, the study of the potential benefits of safety promoting interventions is in its infancy. A study conducted by Taylor et al. (2002) field-tested a one-hour safety-planning class with 48 women with mobility disabilities. The curriculum addressed the cycle of violence, risks for abuse, self-protection skills, and safety planning. Following participation in the class, the women exhibited significant increases in abuse knowledge and safety planning self-efficacy.

Referred to earlier in the paper, our recently completed *Safer and Stronger* study was a longitudinal evaluation of an audio computer-assisted self-interview (A-CASI) program designed to increase Disabled and Deaf women's awareness of interpersonal violence, risk factors, and safety promoting behaviors (Oschwald et al., 2009). A-CASI technology provides several advantages for users with disabilities, including self-pacing, choice of audio, text, and American Sign Language (ASL), branching of questions for participants with particular access needs and characteristics (e.g., gender, positive violence screen, use of personal assistance), exposure to video clips of survivors with disabilities providing affirming messages, and anonymity from mandatory abuse reporting. The 305 participants in the study were randomly assigned to an intervention group that completed the *Safer and Stronger* program or a control group that completed a general health promotion computer program. After three months, all the participants completed the *Safer and Stronger* program. We examined all of the women's responses to the *Safer and Stronger* program, as well as compared the responses of the women in the two groups. The *Safer and Stronger* program was well received and considered accessible (Oschwald et al., 2009): 86% of the participants reported they preferred using the program over discussing violence with family, friends, or professionals; 93% said the program was accessible for them; and 96% said the program would be helpful for other women with disabilities. There were no significant differences in the response to the program between Caucasian women and women of color; however women over the age of 65 indicated a lower preference for using the program, in contrast to the younger participants. At the three month follow-up, when compared to the women in the control group, the women who completed *Safer and Stronger* were more likely to say they: (1) thought about interpersonal violence in their lives, (2) identified ways people were treated and decided if interpersonal violence existed, (3) thought about ways to be as safe from interpersonal violence as possible, and (4) talked to someone about interpersonal violence and their safety (Hughes et al.,

2009). Women who did not disclose interpersonal violence in the past year showed the most notable outcomes, highlighting the potential preventative function of the *Safer and Stronger* program.

We are currently conducting a randomized, controlled evaluation of a peer-led group safety awareness intervention program for women with disabilities (Hughes et al., 2009). Entitled *A Safety Awareness Program for Women with Disabilities (ASAP),* it has been implemented at ten centers for independent living (CILs) in eight states, involving 213 women with diverse disabilities. The program consists of eight, two and one-half hour sessions delivered over eight weeks, which address topics such as safety awareness, self-advocacy, the nature and dynamics of interpersonal violence, safety promoting behaviors, safety planning strategies, and healthy relationships. The core components of *ASAP for Women* are drawn from *Stop the Violence, Break the Silence*, a training guide developed by Disability Services of SafePlace in Austin, Texas (Hughes & Abramson, 2000). The program also includes components found to be effective in the researchers' previous intervention studies (e.g., Hughes, Nosek, Howland, Groff, & Mullen, 2003; Hughes, Robinson-Whelen, Taylor, & Hall, 2006; Hughes, Taylor, Robinson-Whelen, Swedlend, & Nosek, 2004), such as self-efficacy training and interactive activities to encourage mutual support. We expect that women who participate in traditional CIL services plus *ASAP for Women* will report greater improvements on measures of factors found to be protective against abuse (e.g., self-efficacy) after the intervention and at a six-month follow-up than a comparable group of women who receive only traditional CIL services. Preliminary evidence from a small pilot study suggests that participation in such a safety awareness group program can result in improvements in safety-planning self-efficacy, safety skills, safety promoting behaviors, and social network support (Pepper, Hughes, Robinson-Whelen, & Legerski, 2009). We anticipate finding even stronger results from the larger, controlled trial described above.

Analysis of Research

Methodological Challenges

Interpreting the growing body of research on violence against women with disabilities is particularly complex due to the different definitions of disability and interpersonal violence used across studies and the different methods used for participant identification and recruitment. Population-based studies that have randomly telephoned all women and ask a question or two to identify women with disabilities, generally asked about women's experience of typical forms of abuse by intimate partners (physical, sexual, emotional; e.g., Martin, et al., 2006). Other studies that used convenience samples of women with disabilities recruited in the community often examined Disabled women's experience of both typical and disability-related forms of violence, as described above (e.g., Curry et al., 2004). Across different studies, definitions of disability have included both diverse categories, such as mobility, cognitive, mental health, hearing and vision (e.g., Curry et al., 2009; Hughes et al., 2009), activity limitations (e.g., Smith, 2008), and physical disabilities (Nosek et al., 2006). Study participant recruitment methods have included randomized telephone surveys (e.g., Smith, 2008), outreach through health clinics, consumer organizations and service providers (Hughes et al., 2009; Oschwald et al., 2009; Pepper et al., 2009), and identification by professionals (e.g., Nannini, 2006). Each of these approaches has limitations which must be considered when interpreting the findings. For instance, outreach through disability service providers typically misses a large proportion of women with disabilities who do not receive formal disability services. Likewise, general population survey questions that ask about intimate partner violence may miss violence by family, friends, or service providers, including personal assistants who are not intimate partners. Telephone-based surveys often miss persons who are Deaf or hard-of-hearing, those with communication and cognitive disabilities who may not answer the telephone, people with physical disabilities who cannot answer the phone in

the number of rings allotted, people in group homes or other institutional settings, and people who for cultural or other reasons may not self-identify as experiencing an impairment or disability. Finally, many surveys fail to collect information about disability-specific forms of violence, such as manipulating medications or damaging assistive equipment. Nosek, Howland, and Hughes (2001b) identified eleven issues for investigators to consider when conducting research on violence against women with disabilities. Recommendations include using literature-based definitions differentiating emotional, physical, sexual, and disability-related abuse; administering appropriate disability-sensitive measures; using population-based sampling methodologies; and understanding the specific legal requirements for reporting abusive incidents against people with disabilities. Funding is needed for a truly representative study of violence against individuals with disabilities.

Consequences of Interpersonal Violence

In contrast to our knowledge about the nature of interpersonal violence against women with disabilities, relatively little is known about the consequences of this violence. There is evidence from research conducted on women in the general population that interpersonal violence increases the risk of death, physical injury, gynecological disorders, pregnancy difficulties, psychological problems, including depression and suicidal behavior, social isolation, alcohol and other drug abuse, and sleep and appetite disturbances (National Center for Injury Prevention and Control, 2006). Research on secondary conditions is just beginning to detect the effects of interpersonal violence on women with pre-existing disability. For example, abuse has been linked with increased stress in women with disabilities even after controlling for demographic and disability factors (Hughes, Robinson-Whelen, Taylor, Peterson, & Nosek, 2005). Women with spinal cord injury who reported abuse showed greater levels of depression than those who had no known experience of abuse (Hughes, Swedlund, Petersen, & Nosek, 2001). Further research is needed to more clearly identify

the consequences of interpersonal violence for women with disabilities, particularly those effects which could be mediated by appropriate conditions and support. Among the areas that need to be investigated are the impact of interpersonal violence on Disabled and Deaf women's physical and mental health, use of drugs and alcohol, employment, independent living, and social isolation.

Beneficial Support Approaches

Further research also is needed on the effectiveness, accessibility, and appropriateness of existing services for interpersonal violence and survivors with disabilities. Virtually no research has focused on culturally-specific supports for Deaf and Disabled survivors of diverse ethnicity and race or those who identify as lesbian, gay, bisexual, or transgender. These areas should be top priorities in future research. Another top priority is that programs designed for the general population of violence survivors should be evaluated for their responsiveness to Disabled/Deaf women and their compliance with the Americans with Disabilities Act (ADA), as demonstrated by the absence of architectural, communication, and other barriers to participation. The relationships between legal compliance and organizational culture also should be examined. Likewise, disability organizations should be evaluated for their capacities to identify and refer Deaf/Disabled women violence survivors to appropriate sources of help. DV/SA and disability advocates have begun to collaborate on cross-training activities. It is particularly important to evaluate the benefits of policy and practice changes resulting from those collaborations and to make recommendations for successful collaborations that effectively serve these women.

As mentioned above, Deaf and Disabled survivors of interpersonal violence face many barriers to obtaining support, including lack of accessible services, too few service providers with disability-related training, unwillingness or stated inability by providers to provide mandated communication supports (e.g. ASL interpreters) or other services/equipment, and limited options for accessible transportation. In recognition of these

barriers, researchers are studying community-based programs for women with disabilities that address problems common for violence survivors. For example, group interventions that address stress (Hughes et al., 2006), depression (Robinson-Whelen et al., 2007), self-esteem (Hughes et al., 2004), and health promotion (Hughes et al., 2003) have been rigorously evaluated. These programs are grounded in self-management principles, feminist psychology, and the philosophy of the independent living movement that promotes having control over one's life, making decisions, performing daily activities, and fully participating in the community. Disability-sensitive interventions are needed that address other issues known to co-occur with interpersonal violence, such as post-traumatic stress and substance abuse.

Violence Against Disabled or Deaf Women Members of Other Minority Groups

Very little research has focused on the issues and needs of survivors who are ethnically or racially diverse. Service providers and researchers in this area must consider both a woman's ethnic and cultural background and her needs and identity as a Deaf and/or Disabled woman (Lightfoot & Williams, 2009b). These dual or multiple identities can some-times create additional barriers to services, such as a lack of culturally competent staff, experiences of oppression based on both disability and ethnicity, language barriers (which can be two-fold for Deaf and hard of hearing women who use a non-ASL form of sign language), and the sense of having to choose between racial/ethnic identity and identity as Disabled/Deaf women when seeking services (Lightfoot & Williams, 2009b). Additionally, cultural definitions of and norms regarding both disability and violence may vary widely, as may views on what types of interventions are culturally acceptable in addressing violence (Cramer & Plummer, 2009). It is critical to involve both Disabled and non-Caucasian women in various research roles (Nosek, Howland, & Hughes, 2001b). This involvement in research and service provision may facilitate better understanding of the complicated interactions of

ethnicity and disability in the context of violence (Lightfoot & Williams, 2009a; Lightfoot & Williams, 2009b).

Involving women who are dually Disabled and/or Deaf and non-heterosexual can contribute to an increased understanding of the intersections of sexual orientation, disability, and interpersonal violence. Regrettably, we know of no research studies on violence against Disabled/Deaf women who identify as lesbian, gay, bisexual, or transgender. O'Toole (2000) notes that Disabled lesbians are not recorded in either studies of abuse or disability but that they frequently experience discrimination in other health and mental health care settings due to their sexual identity, identity as Disabled/Deaf, and the interaction between the two (O'Toole & Brown, 2003). Thus, it is imperative that researchers confidentially ask about gender and sexual identity along with other demographics and that they report on relevant findings. Research is needed to help understand these types of sexual and disability identity complexities, which can greatly influence the acceptability and accessibility of safety-related information and resources.

Nothing About Us Without Us: Research in Partnership with Disabled Women

Traditional research on disability relies on the expertise of the investigator, while failing to recog-nize the expertise of the people with disabilities who serve as research participants (Kitchen, 2000). At the most basic level, "Nothing About Us Without Us" affirms the critical importance of directly asking Disabled and Deaf women about their experiences and recommendations, and providing supports that maximize their participation. Much of the early information about interpersonal violence against women with disabilities and Deaf women came from professional and family reports. Some groups, such as women with intellectual and mental health disabili-ties, continue to have little direct voice in describing their experiences and needs, and many of these women doubt they will be believed. In addition to supporting women's direct role as research partici-pants, Hughes (2006) called for researchers to

"involve women with disabilities in every phase of the project: planning, design, implementation, evaluation, and dissemination" (p. 49). One method for assuring the direct involvement of Deaf and Disabled women is the use of participatory action research (PAR), which is an inclusive, emancipating, and empowering research approach designed to equalize the power among researchers and "those researched" via a meaningful partnership (Kitchin, 2000). When using PAR, researchers and people with disabilities partner to establish the research questions, to design methods for recruiting research participants, to carryout research tasks and activities, and to interpret, write and disseminate findings. Violence researchers committed to PAR can partner with self-advocacy organizations, centers for independent living, mental health consumer/survivor organizations, and other peer-based groups.

Application to the Field

Policies that Promote Women's Safety

At the national level, policies and practices are being advanced to ensure that advocates and legislators understand the dynamics of interpersonal abuse and learn about strategies to promote personal safety among people with disabilities. For example, at the 2006 National Council on Independent Living (NCIL) conference, NCIL adopted a resolution to address victimization of people with disabilities, entitled: "Violence and Abuse of People with Disabilities." This Resolution states that NCIL will encourage the administration and legislature to (1) allocate resources to improve access to services for persons with disabilities who are victimized and address legislation and public policy affecting victims with disabilities, (2) encourage its members to develop strategies to address violence/abuse of people with disabilities, and (3) advocate for equal access to victim services and promote justice for people with disabilities who are victims of violence/abuse (National Council on Independent Living, 2006). The Violence Against Women and Department of Justice Reauthorization Act of 2005 (HR 3402, commonly known as VAWA) expanded

funding for disability education, training, and services grant programs. Areas of notable focus include building collaborative relationships between victim service and disability service organizations and including added construction and personnel costs for shelters that serve Disabled victims of domestic violence (National Coalition Against Domestic Violence, 2007). While these initiatives signal increasing recognition of the problem of violence against individuals with disabilities, additional policies and enforcement are needed to ensure the availability of responsive and accessible anti-violence services and resources for Disabled/Deaf women.

Guidelines or policy changes requiring physicians and other health care providers to receive training in violence and disability issues are also needed. Health care providers can become effective agents of change by receiving training from community-based experts in the DV/SA field , disability rights advocates, service providers, legal defense groups, and other organizations (Nosek, Hughes, Taylor, & Howland, 2004; Hughes, 2005). Providers should also be made aware of the unique risks for violence associated with disability, and they should be provided with tools that would allow them to address disability-related needs of interpersonal violence survivors and, thus, to work more effectively in increasing the health and safety of women in this population.

Responsive and Accessible Services

Research documents the seriousness of the problem of violence against women with disabilities and Deaf women. However, we have a long way to go in achieving the overarching goal of providing women with disabilities and Deaf women full and equal access to community-based violence services. Most of the current resources in the area of violence and disability continue to be directed toward training service providers and providing specialized services to "protect" victims with disabilities. We must shift from these specialized, protection-focused approaches to empowerment-focused approaches that proactively communicate that people with disabilities

have a right to be safe and have access to information and resources needed to prevent and stop interpersonal violence. It is also critical that disability service organizations learn to address violence from a social justice perspective, following the model of many victim services programs. Likewise, many victim services program, including domestic violence shelters and sexual assault and crisis programs, struggle with providing accessible services to clients with disabilities or those who are Deaf. Victim service agencies must increase their physical, programmatic, attitudinal, and communication accessibility. If victim services programs are not accessible, women with disabilities will neither seek support nor feel welcomed when they reach out. Additional funding is needed to assist these programs, many of which operate with shoe-string budgets, in improving their accessibility, and program leaders must be willing to make accessibility a priority. The following key actions could be taken to increase accessibility and responsiveness to interpersonal violence survivors with disabilities.

· Provide every person with a disability and Deaf persons with information about violence, safety promotion, and DV/SA advocacy and support groups, and help them screen for interpersonal violence and connect with resources, as they desire.

· Conduct cross-training activities and develop protocols, agreements and funding strategies that enable victims' service organizations to increase their accessibility; that increase the capacities of community disability organizations to assist individuals to access resources; and that build linkages among violence, criminal justice and disability organizations and agencies.

· Involve centers for independent living, self-advocacy organizations, psychiatric consumer/survivor groups, and other peer organizations in interpersonal violence education, screening, and support activities.

· Ensure that a survivor who discloses interpersonal violence will not be placed in a group home or institution nor have her children or companion animals taken away.

· Provide a 24-hour crisis line for survivors with disabilities/Deaf survivors to talk with an advocate experienced in disability and victim services.

· Provide and fund emergency interpreter, personal assistance, child and pet care, and transportation services that survivors and the organizations that serve them can call upon.

Violence Against Men with Disabilities

Although not as well-studied as violence against women with disabilities, violence against men with disabilities has been shown to be a serious problem (Cohen, Forte, DuMont, Hyman, & Romans, 2006; Marchetti & McCartney, 1990; Powers et al., 2008, Saxton et al., 2006). For example, Adult Protective Services (APS) abuse-reporting data for people with developmental disabilities, a population where mandatory reporting is common, suggest that men and women experience similar levels of abuse. In one APS study involving physical abuse, the male to female victim ratio was found to be 56% to 44% (Marchetti & McCartney, 1990). In their review of 85 confirmed cases of sexual abuse among persons living in staffed housing, Brown, Stein, & Turk (1995), found that men with developmental disabilities were as likely as women with developmental disabilities to be victims. Our survey of 345 men with physical and intellectual disabilities living in the community, including 143 men with developmental disabilities, found that 65% of the men reported lifetime physical abuse while 24% of the men reported lifetime sexual abuse (Powers et al., 2008). Unlike perpetrators of violence against women, the perpetrators described by the men in this study were not significantly more likely to be male than female. The abuse the men reported had negative consequences across their lives: 18.6% of the men said the abuse impeded their employment, 31.1% said the abuse kept them from taking care of their health, and 21.1% indicated the abuse was a barrier to living independently. Compared to men without intellectual disabilities, men with intellectual disabili-

ties were two times more likely to report providers manipulating their medications; they were nearly three times more likely to report being held against their will, and they were two and a half times more likely to report being hit, kicked, slapped, or otherwise hurt. Existing research suggests that men with disabilities share many similarities with women with disabilities regarding the types of abuse they experience and the impact of the abuse on their lives. However, Disabled men's response to abuse appears complicated by gender role expectations that discourage men from acknowledging abuse and lead others not to believe them, as well as by the lack of accessible and welcoming DV/SA services for men. In partnership with male interpersonal violence survivors, our team is currently developing a computer-assisted abuse and safety awareness program for Deaf and Disabled men. Further research and additional services are urgently needed to increase our understanding of Deaf and Disabled male survivor's experiences and to expand men's access to responsive safety resources.

Conclusion

Growing evidence confirms earlier findings that the presence of disability in women's lives increases their risk of interpersonal violence beyond that experienced by women in general. Moreover, research has demonstrated that women with disability and Deaf women have to contend with typical and unique forms of violence and types of perpetrators. Although studies have identified barriers and facilitators experienced by Disabled and Deaf women in promoting their safety from violence and in accessing safety resources, there is an imminent need for advancing the knowledge base in this area. Specifically, it is critical for research to replicate studies and validate earlier findings in different settings and among subpopulations within the disability community; to identify and recommend policy solutions to the barriers experienced by Disabled and Deaf women in accessing safety; and to evaluate existing abuse education and safety planning programs to determine their effectiveness in meeting the unique safety needs of women with

disabilities. Finally, the knowledge gained from research must continue to be translated into practical applications for service providers in order to yield the greatest benefit for individuals in the disability community who are at elevated risk for and/or victimized by interpersonal violence.

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In Brief: Interpersonal Violence and Women With Disabilities: A Research Update

While a relatively young field of inquiry, research on violence against Disabled and Deaf women offers compelling evidence for their greater risk for experiencing physical, sexual, and emotional violence than women without disabilities. In addition to these traditional forms of violence, women with disabilities and Deaf women are at risk for disability-specific forms of violence including medication manipulation; destruction of adaptive equipment such as wheelchairs and communication devices; neglect by people who assist them with activities of daily living such as eating or bathing; and financial abuse. This additional vulnerability means that perpetrators of violence against women with disabilities and Deaf women include not only intimate partners, such as spouses, but also family members, friends, healthcare providers, and paid or unpaid providers of personal assistance. For this reason, the authors propose the broader term "interpersonal violence" (IPV) be used instead of the more traditional "intimate partner violence" when researching and discussing violence against women with disabilities.

A small but ever-growing body of literature addresses ways to reduce the risk for and experience of IPV among Disabled and Deaf women. Women living with disability face not only traditional and disability-specific forms of abuse but also unique barriers to leaving and reporting abusive situations, such as mobility and accessibility barriers, fear of losing their independence, and dependence on the perpetrator for assistance with daily life activities. Because research on the prevalence and nature of violence against Disabled women was not initiated until the late 20th century, investigation of the benefits of safety promoting interventions is in its infancy. Research conducted to date or currently underway highlights improvements in Disabled women's abuse awareness and knowledge, safety planning, safety planning self-efficacy, safety skills, safety promoting behaviors, and social networks. Notable gaps exist in the research related to the issues and needs of ethnic or racial minority survivors, and/or survivors who are gay, lesbian, bisexual or transgender.

There are numerous methodological issues that must be considered when conducting research with Disabled and Deaf women. Interpretation of the growing body of research is particularly complex due to the diverse definitions of disability and IPV applied across studies and the different methods used for participant identification and recruitment. Researchers are urged to use literature-based definitions differentiating emotional, physical, sexual, and disability-related abuse; to administer appropriate disability-sensitive measures; and to use universally accessible population-based sampling methodologies. Researchers need to understand that telephone-based surveys and surveys of people who receive disability-related government services may exclude certain of segments of the disability community. In addition to these methodological considerations, the authors stress the importance of involving people with disabilities in all phases of research, from designing studies to disseminating the findings.

The authors call for continuing advancement of legislation and policies; acceleration of efforts to provide responsive and accessible services, and disability-specific violence training for professionals; and attention to the issue of violence against men with disabilities.