EASY PREY: EXPLORING ABUSE AMONG WOMEN WITH DISABILITIES

BY

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A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF ARTS

Department of Sociology
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Winnipeg, Manitoba

ISBN 0-612-12955-1

Canada

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ABSTRACT

Research on the abuse of women with disabilities is limited, yet some studies show that women with disabilities are twice as likely to face abuse as non-disabled women. In order to gain some understanding of their experiences of abuse, eighteen women with disabilities were interviewed. These interviews were part of a larger Abuse Research Project conducted by the Independent Living Resource Centre in Winnipeg, Manitoba, Canada.

The research sought to examine abuse and violence against women with disabilities with the goal of beginning to systematize our understanding of this area. Interviews revealed that women with disabilities in this study perceive women with disabilities as "easy prey" for abuse and violence. A conceptual framework was extrapolated from the existing literature on violence against women. This framework was then modified to examine the violence and abuse of women with disabilities. The analysis of the data highlighted the experiences of abuse for women with disabilities, the various factors that predispose women with disabilities to abuse, the impacts of abuse, and possible sites of intervention.

Results emphasize the need to address this problem among women with disabilities, and the need to make changes in societal attitudes and institutional structures. The research also points to a need for the full inclusion of women with disabilities in the feminist and disability movements. Finally, although there are some differing nuances, the abuse of women with disabilities in this

study is not that different from the abuse experienced by women generally. Their vulnerability is also very similar to that of other vulnerable groups, such as children and elderly persons. This suggests new areas of learning and potential alliances in tackling this problem. It also strengthens the idea that this is a social, rather than individual, problem, which is prevalent in our society, and which needs social solutions.

ACKNOWLEDGEMENTS:

I cannot believe how hard it is to write acknowledgements. There are so many people who have been involved along the way. A big thanks to everyone who has encouraged and supported me in one way or another over the last two years.

I would like to thank Karen Grant for encouraging me to take up this enterprise again and for advising me on the way. I'm glad we met at the Medicine Rock Cafe. Thanks also to my committee members, Zana Lutfiyya and Jane Ursel, for their valuable insights and opinions. Thank-you all for taking the time and energy to help me emerge with a better product.

I would also like to express my thanks to the women whose voices are contained in this thesis. I thank them for sharing their private lives with me. I hope that this work accurately reflects what they expressed. I hope their words give strength and courage to others, and that by speaking, they do in fact make things better for others.

I would also like to acknowledge the support and encouragement of the Independent Living Resource Centre here in Winnipeg. First, thanks for allowing me to utilize the interview data for this thesis. Second, thanks to everyone (you know who you are) who listened to my struggles and gave me endless hours of support and persuaded me to keep going.

Thanks to Colleen for helping out when I needed it, particularly when a "munchie" run was needed.

I also thank Twylla who quietly encouraged me to continue in this quest. Good luck in pursuing your Ph.D.

Finally, deepest thanks to my partner Sally, who tolerated my moods, my frustrations, and my desire to see this finished. Your support and assistance behind the scenes, especially when I wanted to give it up, kept me hanging in there. Thanks for being there and for pushing me.

I am glad to have this work complete. There were times when I never thought I would be able to say that. I hope this work contributes to the body of knowledge on abuse, and I hope that it helps improve the situation for women with disabilities.

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CHAPTER ONE: INTRODUCTION

In The Sociological Imagination, C. Wright Mills (1959) talked about our societal tendency to psychologize problems, which in turn privatizes individual troubles. The view expressed in The Sociological Imagination is that an "individual can understand [her] own experience and gauge [her] own fate only by locating [her]self within [her] period, that [she] can know [her] chances in life only by becoming aware of all those individuals in [her] circumstances" (1959, p. 5). This demonstrates the necessity of placing the individual's circumstances in a larger context, and finding the similarities and differences to those in similar and dissimilar contexts. Mills points to the necessity of examining the intersections of biography and history, by considering three types of questions (1959, p. 6). The first question has to do with the essential components and structures of a society, including what is valued in the society. The second refers to where this society currently is in terms of human history, and how this differs from other periods; this would include different notions regarding disability and its treatment. The final question relates to the kinds of human beings and types of human nature found in the particular society. What these questions point to is the need to look beyond the purely personal to the social.

Mills writes that individual or personal troubles "occur within the character of the individual and within the range of [her] immediate relations with others.... A trouble is a private matter:

values cherished by an individual are felt by [her] to be threatened" (p. 8). However, if something is happening on a significant scale, Mills instructs that we must begin to see this as a public issue. "Issues have to do with matters that transcend these local environments of the individual and the range of [her] inner life. ... An issue is a public matter: some value cherished by publics is felt to be threatened" (p. 8). Public issues have causes in the social structure, and therefore, to solve a structural issue, "requires us to consider political and economic issues that affect innumerable milieux" (p. 10).

Since the root of the issue is in larger social structures, the individual is relatively powerless to solve the troubles imposed on her from the system or lack of system (Mills, 1959). Therefore, we must look beyond the personal and find the common threads among the occurrences. We must begin to examine both the individual and systemic bases for the reasons it occurs with such frequency. In other words, we must look at the existence of individual problems, and how they are dovetailed with social context and social history.

This thesis addresses the issue of abuse and violence against women with disabilities[1] using the backdrop of a feminist

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[1] In order to counteract or at least make cognizant the objectification/medicalization of women with disabilities, the term "women with disabilities" will be used instead of the shorter "disabled women." This does two things. First, the language notes the importance of both realities--disability and gender. Second, by placing the disability after the woman, the woman is seen as a person first. In this way, she is more than just a medically defined entity. She is a person with feelings, aspirations, etc. who is more than her disability. The term "non-disabled" will be used instead of "able-bodied," in recognition of the varying nature of disabilities. The description "able-bodied" may be exclusive of those women who are physically "able" but who have hidden disabilities or disabilities which affect their intellectual, psychiatric or sensory functioning. These women still experience disability concerns.

perspective.[2] Research from this perspective provides the framework for my analysis. I conceptually explore the experience as occurring in a society which is both patriarchal and ableist in nature. I address the traditional dichotomy of women with disabilities in research, whereby their issues are most often examined from either a disability perspective which does not pay particular attention to gender, or from a woman's perspective which may not appreciate the realities of disability. Referring to a nomadic existence with dual status in both movements, Blackwell-Stratton et al. (1988) refer to the reality that neither the disability nor women's movements fully address the concerns of women with disabilities. Feminist research is drawn upon in order to discover factors which contribute to explaining the reality of abuse and violence against women with disabilities.

I will focus on the experiences of abuse of women with disabilities, to explore the notion expressed that women with disabilities are "easy prey." A conceptual framework is developed in order to explore women's definitions of abuse, factors which predispose women to abuse or act to keep them in abusive situations, the various impacts of the abuse, and possible sites for interventions. In examining the impact of abuse on women with disabilities, some important contributions may be made to the

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[2] Since this research deals with the particular experiences of women with disabilities, the language employed will reflect that the experiences are gender-based. It is important to see these experiences as female. Too often, the life experiences of women with disabilities are equated to those of men with disabilities. Clearly, there are unique and important differences. Therefore, female referents will be used throughout rather than "she/he" attempts at inclusiveness.

understandings of identity, self-image and self-esteem of women with disabilities. This study will not only document the anecdotal accounts of women with disabilities, it will also generate an experientially based analysis of abuse or violence as articulated by women with disabilities. As such, it points to future areas for study.

The variations in the relationship between abuse and disability are numerous. Abuse can happen to a girl or woman who has a disability. Abuse can contribute to an existing disability, either exacerbating a condition or adding dimensions to it. Abuse might actually result in a disability. A disability might also increase an individual's vulnerability to abuse, or increase the perception of vulnerability to abuse. I cannot draw causal connections, but the belief expressed during an interview by one woman with a disability was that she and other women with disabilities are "easy prey." This is the guiding premise of this study. This perception is not held equally among women with disabilities, but it is a factor for some women. It is also a belief held by some abuse perpetrators, who may be searching for an "easy" victim.

The literature on violence and abuse, women, and disability is reviewed in Chapter Two. Chapter Three consists of a presentation of a conceptual framework extracted from the existing feminist literature on wife battering and abuse. In Chapter Four, I discuss the research methodology and the larger Independent Living Resource Centre (ILRC) abuse project. Chapter Five contains the descriptive presentation of data. This includes brief life histories and overall

demographics. Chapter Six explores the usefulness of the conceptual framework in understanding the abuse experienced by women with disabilities. Finally, in Chapter Seven, I consider the major findings, discuss the implications of this study, and make recommendations pertaining to the study of violence against women with disabilities and regarding the societal response to violence against women with disabilities. Also in this concluding chapter, the limitations of the research are discussed.

CHAPTER TWO: REVIEW OF THE LITERATURE

2.1 THE PROBLEM

Violence as a Social Problem

Violence against women with disabilities is an issue which has only recently been studied. In part, this is because the experiences of women with disabilities have not been widely studied (Fine and Asch, 1981). Perez (1993) notes that although some writing about women with disabilities began to appear in the 1980's, the needs of disabled women remain largely unidentified and unexplored. This situation is compounded by the relative lack of attention paid by researchers and governments to violence against women as a social problem. In fact, it is only in the last ten or fifteen years that violence against women generally has been viewed as a "social" issue, rather than an "individual" problem (i.e., as involving more than isolated instances of individual men perpetrating violence against individual women). We are beginning to see an increased recognition that psychological theories of battering are inadequate (MacLeod, 1987). With the rise of feminist theories and analyses, the conceptualization of the nature and causes of this violence has undergone some major changes, and violence against women has increasingly been viewed as a function of systemic patriarchy.

Scant Research

The pervasiveness of the problem of violence against women is finally beginning to be recognized. However, this is within the

context of a sketchy body of research. There is an increased awareness of the existence of violence against women, and an increased acceptance of this being a bona fide area of study. Despite being seen as an acceptable field of study, research has not focused on the experience of all women. Some areas of women's experience have been more widely researched than others (i.e., racial differences, able/disabled, etc.).

A discussion paper examining research "By/For/With Women With Disabilities" noted the importance of research in learning about the world and explaining its events. This paper notes that Canadian universities "have been criticized for the limited research on the life experiences of women, people with disabilities, natives and elderly Canadians" (Wight-Felske, 1990, p.1). The experiences of disabled women have been particularly neglected. There is very little research about women and disability (Wight-Felske, 1990). Awareness-raising is important both in the area of women's studies and the area of disability research.

The 1990 Canadian Research Institute for the Advancement of Women (CRIAW) Conference focused on women with disabilities and highlighted the need for a greater degree of collaboration between all women, both in the women's movement and in research on women's issues. The major areas covered at the conference included difference and disability, herstory, caregiving and mothering, and language and writing (Stewart, Percival and Epperly, 1992). The papers in this collection emphasize the need for all women to join together in an examination and appreciation of difference and

diversity.

Need for Inclusion

Women with disabilities are typically not included in the women's movement or women's research, and they are also excluded from the disability movement and disability research (Stewart, Percival and Epperly, 1992). Sobsey and Varnhagen (1988) compiled an annotated international bibliography, which revealed that much of what was available included theories of cause and effect; statistics; strategies for education/intervention/treatment; training information for professionals; and issue based resources. Topically, much of what appears in the literature specific to abuse and disability relates to children with disabilities, people (generically) with disabilities, elderly people, people labelled "mentally handicapped." Most research focuses on sexual abuse (Sobsey and Varnhagen, 1988; Sobsey et al., 1991).

A review of the annotated bibliography produced by Sobsey et al. (1991) indicates that much of the research is based on opinions of service providers, experts and/or professionals, organizations, and so on. There needs to be more research based on consumer[3] experience (i.e., people with disabilities). Sobsey et al. also note that less research is available which documents physical and other

[3]The word "consumer" is commonly used in the Independent Living Movement, and refers to a person who utilizes services, in this case, a person with a disability who uses the services of the ILRC. Consumer best describes the notion of people having a choice in decisions made about them and their situations. This terminology emphasizes the locus of control as being with the person with the disability who is a person capable of making decisions and taking risks vs. with the provider of service (which is implied by terms such as "client" or "patient"). This is one part of the Independent Living (I.L.) Philosophy.

assaults against adults with disabilities. Thus we have a situation where the unique aspects of being disabled are ignored by those doing research on women, and research examining abuse and disability overlooks the unique experience of being a woman (Wight-Felske, 1990).

The existing research, in addition to being limited in these ways, has also been of either an epidemiological (i.e., incidence and prevalence) or anecdotal nature. In other words, the focus has been on determining how much abuse has occurred and to whom, examining consequences for service utilization, or gathering together collections of individual stories or accounts of incidents. These emphases have persisted despite the problems inherent in using official statistics and reported cases.

Problems of Statistical Studies

Official statistics (such as police reports) limit the number of cases which are counted. Statistics Canada (1993, p. 7) relates that "It is well known that, for a variety of reasons, a significant proportion of all types of criminal incidents are not reported to the police." In the Violence Against Women survey (Statistics Canada, 1993), it was suggested that only 14% of all violent incidents were reported to the police. As well, they noted a range in rates of reporting depending on the nature of the offence. Physical assaults were more likely to be reported to the police (28%) than sexual assaults (6%)(Statistics Canada, 1993). As one progresses through the system of police reports, charges laid, court appearances, and convictions, fewer and fewer cases emerge (and therefore fewer

cases are available for counting). This is analogous to utilizing increasingly finer screens in examining a bucket of mixed gravel and silt, so that only a small portion of sample remains at the end. Another frequent analogy, often used particularly with issues of reporting sexual abuse and sexual assault, is that reported cases reflect the tip of an iceberg (Turk and Brown, 1992).

Under-Reporting of Abuse

Under-reporting and narrow definitions limit much of the helpfulness of this research. Why we have fewer reported cases is also due, among other factors, to fear of the consequences of reporting (for example from the perpetrator), fear of not being believed, and fear about the justice process being worse than the original crime (e.g., as in the "revictimization" that occurs in many sexual assault trials) (MacLeod, 1987). These factors may be more cogent for individuals with disabilities who are rarely believed at the best of times and who may be dependent on caregivers for personal care and independence. Ryerson (1981), for example, estimated that less than 20% of cases of sexual assault of people with disabilities are ever reported. Other studies, such as noted in Sobsey and Varnhagen (1989), corroborate this by saying that the majority of cases of sexual abuse involving disabled people are never reported to the police, community service agencies, or other authorities. Other factors which might have an impact on reporting could include different definitions of abuse and violence, varying levels of tolerance for different actions, willingness to report, and memory (Turk and Brown, 1992).

In addition to the limitations of studies based on official statistics, much less exploratory, experiential, consumer-based research has been done. The exceptions to this are several recent collections of anecdotal information which provide a valuable contribution by conveying the pervasive discrimination and issues faced by women with disabilities (Perez, 1993). However, at this relatively new point in research, more exploratory research is still required. The exploratory research must be done from the perspective of women with disabilities. This study is intended to help fill that need.

2.2 THE DISABLED WOMEN'S NETWORK

Some recent and consumer-based work has been done by the DisAbled Women's Network (DAWN) Canada on women with disabilities and the issues which they identified as of importance. DAWN Canada is a network of women that was formed in the mid-1980's in order to advocate for the unique needs of women with disabilities. In many ways, this movement was necessitated by the exclusion of disability issues from the feminist community and the failure of the mainstream disability movement to represent the needs of women. Perez (1993) suggests that DAWN has the potential to act as a bridge between the women's movement and the consumer (disability) movement.

The founding meeting of DAWN Canada was held in Ottawa in 1985. Seventeen women with disabilities met to discuss topics of importance to them. Based on this initial networking, a research

project to discover what the primary issues were for Canadian women with disabilities was undertaken by DAWN Canada in 1988. The foundation for the project was the development and distribution of an extensive survey to 1200 women with disabilities, as well as some subsequent interview data.

Criticisms were raised about the methodology and the sample of this nation-wide survey. Critiques of the methodology centered around the limited ability of a survey to capture the depth of experience on such complex issues as child-bearing and parenting, violence, employment, and self-esteem. The sample was seen to be limited in that surveys were only sent to those women who were active members of consumer groups, women's centres, or disability organizations. Therefore, it was believed that these women were part of an elite group; i.e., their supports, position and connectedness, were perhaps not representative of the general female disabled population. Additionally, there was greater representation from women in urban centres than rural areas. Finally, no women living in institutions were part of the sample. Although the limitations should be taken into account, none of these criticisms nullify the importance of the findings as a starting place for examining issues such as abuse and violence from the perspective of women with disabilities.

DAWN's work provides a baseline for future research, and more importantly, points to the need for knowledge about the unique and experiential nature of being a woman with a disability. The issues seen by respondents as most important included: the low and

negative self-image possessed by many women with disabilities, the great concern about vulnerability to violence, the general lack of access to employment opportunities, and issues of the difficulty of parenting with a disability (Ridington, 1989 a, b, c and d). The women involved in DAWN Canada believe that it is important to consider issues on an integrated basis. The issues of women with disabilities cannot be extrapolated from the experiences of non-disabled women or of disabled men.

Westcott (1991) notes that regardless of the absolute level, it is known that significant numbers of people with disabilities are abused. We need in the future to develop a more balanced approach and augment future research efforts with a greater focus on experiential research. Then we can begin to address how the problem is experienced by different groups of women, and discover the effects abuse and violence have on women, particularly those of previously neglected groups, such as women with disabilities. Kelly (1988:x) declares that "the prevalence of sexual violence in women's lives is still not publicly acknowledged." This lack of acknowledgement, she asserts, remains despite feminist efforts. Grothaus (1985:125) concurs and adds that "No government-funded studies have been done on the extent of violence against disabled women, or, if they have, they have not been publicized." We need to find out more about the nature of the abuse, its effects on women's lives, and the dynamics which give it life and sustain this abuse. Such accounts may provide a window on how to effect change.

2.3 CANADIAN PANEL ON VIOLENCE AGAINST WOMEN

In 1993, the Canadian Panel on Violence Against Women released its final report detailing the results of an extensive national consultation process on the issue of violence against women. The Panel aimed to document and analyze Canadian women's experiences of violence in order to make recommendations to address the conditions which give rise to and maintain violence against women in this country. Perhaps for the first time, in response to criticisms of previous research, a conscious attempt was made to include the experiences of a wide variety of women including: "older women, women living in poverty including women with low literacy skills, women with disabilities, rural women, lesbians, women of official language minorities, women of colour, young women and immigrant and refugee women and domestic workers," as well as an extensive discussion of the experiences of Inuit and Aboriginal women (Canadian Panel, 1993a, p. 26).

Criticism of Scope

However, despite the inclusive efforts, the Panel fell short of its stated goal. Women with disabilities have claimed that the Panel relied on the opinions of a sub-group of women with disabilities which do not reflect "average" experiences. Local opinion is that the women with disabilities whose opinions were included were more vocal, more organized, and more politically active/aware than the "average" woman with a disability (whatever "average" is). Although this bias is true for all of the women included in the Panel's consultations, it may have even more impact

for women with disabilities as a group, where isolation, low self-esteem, etc. are realities for most (particularly when individuals are not connected up to a community organization or agency). A related criticism is that the consultation was not as far-reaching as it might have been. This related both to the number of organizations contacted, and to efforts to include women not connected with an "official" women's or disability group. Also, despite the funding, research and dissemination, the publicity of the results, particularly as related to women with disabilities in Manitoba, suffers from Grothaus' earlier charge that even when government studies are done, they are not widely publicized or utilized in creating concrete changes (Grothaus, 1985).

Violence and Minority Populations

The final report contains a discussion of the effects of subordination of women to men, dependence on men and male systems, and isolation experienced by virtue of women belonging to other minority populations. One such group of people is women with disabilities (Canadian Panel, 1993b, p. 67-70). The presentation on women with disabilities included an introduction to defining abuse in terms of four major disability types. These included mobility impairment; hard of hearing and deaf; blind and visually impaired; developmental disability, intellectual disability, psychiatric disability and learning disability. They also make mention of people with "invisible" disabilities, such as those with epilepsy or AIDS, and "multiple" disabilities.

So far, the Panel's findings have not generated widespread

comment. However, there are local women with disabilities with whom I have spoken who feel that although some of the major experiential factors were noted, it may be impossible to give justice to the unique situation of women with disabilities in such a cursory presentation. This is because they feel the presentation and analysis was based on able-bodied experiences, rooted in patriarchy; and don't adequately account for women's experiences of ableism. Based on these informal discussions, they suggest that more work needs to be generated from women with disabilities as the primary sources. This position is based on a belief that it is difficult, if not impossible, to understand this reality unless one has lived it or become immersed in it.

Does the Analysis Relate to Other Groups?

The other underlying issue is that the three major factors were identified generally based on "average" white, middle-class, non-disabled women, while the experiences of women with disabilities was later fit into the framework. In other words, a measure which originated in a non-disabled reality was used to organize and measure disabled experiences. Some question whether the main issues/categories may have been different if the analysis had first begun from the perspective of women with disabilities. It is important to include women with disabilities in formulating the questions and the answers (Wight-Felske, 1990), otherwise research runs the risk of just re-creating existing realities and overlooking areas of new knowledge. Part of the critique, then, is that women with disabilities are being fit into "pigeon-holes" they did not

themselves create.

The Panel includes findings from women with disabilities, and situates and analyzes violence in the context of a society that is patriarchal and heterosexist. Other significant bases of inequality which they note are class and race. Differences based on disability are included in the results, but not as significant factors in exploring or explaining violence. This may in part be due to the wide range of disabling conditions, as well as other differences among women with disabilities, such as age, marital status, and sexual orientation, which do not result in a commonality of experiences among women with disabilities.

People with Disabilities on the Outside

Unfortunately this omission ignores the fact that people with disabilities, particularly women, are often ostracized and isolated. This isolation may mean that identity as a person with a disability may be more salient than some of the other factors which were in fact utilized in the theoretical analysis. An essential question which needs to be further addressed at some point is the importance of different sources of oppression for different groups. In other words, there is a need for an exploration of whether classism, racism, sexism, or ableism adds multiple layers to the oppression of women with disabilities.

Despite idealistic notions of integration, people with disabilities are still on the outside of social groups and activities. Foster placement, institutionalization, and segregation within the community are realities. Ours is a society that devalues,

marginalizes and discriminates against people with disabilities. Exclusion, whatever its form, serves also to remove individuals from discourse and everyday patterns of socialization. It would therefore be naive to believe there is no significant effect based on the differential reality of disability.

The Pervasiveness of Abuse

Abuse and violence against women are pervasive problems in Canadian society. The 1993 study conducted by Statistics Canada reported that "one-half of all Canadian women have experienced at least one incident of violence since the age of 16 (Statistics Canada, 1993, p. 1). The National Clearinghouse on Family Violence (1993a) cites research that one woman in four will be sexually abused by the time she reaches the age of 16. Estimates of wife abuse are that one in ten women will be abused by her partner each year (MacLeod, 1987). Clearly violence against women is a pervasive problem in this country.

As noted by the Panel, "everyday in this country women are maligned, humiliated, shunned, screamed at, pushed, kicked, punched, assaulted, beaten, raped, physically disfigured, tortured, threatened with weapons and murdered" (Canadian Panel, Executive Summary, 1993, p.5). Most often, these acts are committed not by strangers, but by those most in positions of trust and close relationships to the women. Individual-based theories do little to explain the wide-ranging nature of the phenomenon (MacLeod, 1987). Violence against women cuts across all socio-economic categorizations (Statistics Canada, 1993; MacLeod, 1987).

2.4 ABUSE AND DISABILITY

Higher Risk of Abuse

Although clearly an issue which impacts on the lives of people with disabilities, violence and the abuse of people with disabilities has not received a great deal of attention. The last ten years have seen more attention focussed on these issues, but much remains to be done. Generally, people with disabilities are at a greater risk of being abused than people without disabilities (Sobsey and Varnhagen, 1991). In fact, based on the literature and various studies, it has been estimated that the risk of abuse is about 1.5 to 2.0 times greater for people with disabilities of the same age and gender as those without disabilities (Sobsey, 1988; Doucette, 1986). This number increases to a ten times greater risk for women with disabilities living in institutions, as compared to non-disabled women living in the community (National Clearinghouse, 1993a, p. 2). This increase is likely due to a number of factors, including greater isolation, increased dependence on caregivers, greater power imbalances, and less ability to speak out or escape.

Rationale for High Rates

There are a number of reasons for the high rates of abuse. First, women with disabilities are vulnerable to abuse by virtue of being women, and all of the related risk and safety factors associated with being women in Canadian society. Second, there are a number of risk factors related to being disabled in Canadian society, a subject to be discussed in detail later.

Sobsey (1988) notes that people with disabilities who are

victimized typically experience more severe abuse over a prolonged period of time. It has also been suggested that for victims with disabilities, the effects of the abuse may be more harmful, severe and chronic (Sobsey, 1988). Reasons for this include lower self-esteem and therefore less resistance to the negative effects of abuse, and less societal control over the abuse. This may be related to Waxman's (1991) dimension of hatred. Waxman believes that an unspoken aspect of negative attitudes and treatment for people with disabilities is based on hatred. Another reason may be that the systems which are an intimate part of the lives of people with disabilities are not quickly changing. Also, there is a lack of service for both the victims and perpetrators of abuse when the victim has a disability. Partly this is due to lack of resources and difficulty accessing those services, but it is also a reflection of the lack of recognition of some types of abuse such as caregiver abuse. Despite this, overall recognition of the problem and its scope, as well as accessibility to services has been limited (Sobsey, 1988; Perez, 1993; Ridington, 1989b).

Many people are still under the misconception that no one would abuse a person with a disability (Perez, 1993). In fact, there are a number of similar myths that contribute to the abuse of people with disabilities or which make it difficult to respond to instances of abuse. The myths are related to the elements of handicap referred to in the sociological distinction between disability and handicap. As noted by Bury (1979) and Stroman (1982), disability refers to actual restrictions of "normal" activity based on biological

or physical impairment, while handicap refer to restrictions on roles, typically as a result of the societal response to the disability. Handicap is usually seen as the stigma which results from the negative attitudes and practices of others, including those people whose services are necessitated by the presence of disability, such as medical professionals, personal care attendants, and so on. Therefore, the myths relate to conceptions held about individuals with disabilities which are not necessarily connected to the biological dimensions of disability, yet which are very powerful factors.

Myths about People with Disabilities

There are a large number of these myths about people with disabilities. Although there are many, five central and interrelated beliefs which act to increase the vulnerability of people with disabilities or make it more difficult to respond effectively to the abuse of people with disabilities are considered below. Some of these myths appear to be contradictory, but all impinge on the experiences of the person.

1) *People with disabilities are like children.* This has been documented by Wolfensberger and Glenn (1973) and Wolfensberger and Thomas (1983). Erroneously, many people believe that individuals with disabilities are not fully functioning human beings with mature adult capacities (Saxton and Howe, 1987). There may be some degree of dependence on others as a result of the disability which then becomes all-encompassing, and which is used to keep people in the state of "perennial child." This infantilization of

people with disabilities nullifies "normal" entitlements of adults in our society. Therefore, it would be acceptable to treat adults like children, including not affording adults basic human rights and dignities. This would include not being given choices, assuming an inability to give informed consent, and otherwise not being able to control events in their lives (Ridington, 1989a). One might wonder if this would be more exaggerated for women who are typically socialized to be more passive and childlike (Perez, 1993; Traustadottir, 1992).

This belief is also related to Euro-Christian, Islamic, Jewish, Asian and other philosophies which view people with disabilities as in need of help (as opposed to assistance), pity and charity (Wolfensberger and Thomas, 1983). This view is based on an attitude of "doing for" versus "doing with" (Saxton and Howe, 1987). This perspective does not see individuals with disabilities as active, able people. Rather, they are forever "needing help," even if they are not themselves aware of this need. This contributes to the power of caregivers and other professionals, with a decrease in individual power and control, and adds to the notion that those involved with people with disabilities are somehow to be congratulated for their patience and effort toward enriching the lives of their "clients." This may shield them from discovery as abusers.

2) *People with disabilities are helpless and highly protected.* Related to the myth of being in a perpetual state of childhood, is the idea that people with disabilities are incapable of making decisions

or exerting personal control, and that the presence of a disability actually serves as protection from abuse (Worthington, 1984; Cole, 1986). Similar to children, they should be protected from danger and exploitation, and there is an added assumption that they would never want to be in, or be a desired partner for, an adult relationship. In fact, women with disabilities are less likely to marry, and are more likely to be divorced or separated than either men with disabilities or non-disabled women (Lonsdale, 1990). Individuals are expected to be the passive recipients of service, and when they are not, they are labeled as troublemakers, as opposed to being seen as good decision-makers (Finger, 1990).

As a result, and because they are seen as "helping" people with disabilities, caregivers are given far more power and control than ought to be the case (Sobsey and Varnhagen, 1988). Perez (1993: 29) states:

> Caretaker abuse is widespread, but most times goes unreported, largely because caretakers are perceived as authority figures. Further, when a report is made, the police tend to regard the caretaker as a "kind person," doing a favour for the client, and therefore, incapable of abuse. [Police] Officers often make the victim feel she has misunderstood or misinterpreted the actions of the caretaker (emphasis in original).

Additionally, if victimization is not included in the realm of possibility, it becomes harder to recognize its existence. This myth, that people with disabilities are protected, and that no one would take advantage of a person with a disability, serves to shield perpetrators from discovery. We don't want to believe that these

abuses can and do happen.

The medical model, which fundamentally is controlled by white, educated, middle-class, heterosexual men, holds central status in the lives of women with disabilities. Areas of life, such as sexuality, sexual orientation, decision-making, and others are taken under the authority of medical practitioners. Women and women with disabilities are prescribed sedatives such as phenobarb and valium as another form of social control. Medical personnel are seen as the only ones qualified to make basic decisions such as where a person should live and with whom. All aspects of a woman's life are interpreted through the lens of disability (Ridington, 1989a). Yet these areas may not even be part of medical knowledge or expertise. Abuse may happen under the guise of treatment, or it may not be recognized as a legitimate problem by the "gatekeepers" of the system, who tend to be medical professionals.

3) *People with disabilities are not sexual.* This refers to two related beliefs. The first is that people with disabilities are sexless, and are not fully functioning men or women (Harris and Wideman, 1988; Finger, 1990). The second makes reference to being asexual and not being or wanting to be sexual beings (Harris and Wideman, 1988; Diamond, 1977; Benefield and Head, 1984). These beliefs perpetuate ideas that people with disabilities do not have sexual urges or feelings and do not engage in sexual activities (Perez, 1993). In addition to discouraging sex education, such that young women with disabilities are not given the information necessary to recognizing abuse, these beliefs also result in a lack of

comparison for healthy sexual activities, and a resultant feeling that "anything [including abusive behavior] is better than nothing." This misconception also leads to disbelief and lack of credibility if people with disabilities report acts such as rape. This basic lack of credibility becomes exaggerated by other factors such as difficulty communicating, perceived lack of intellectual capacity, and reliance on alternate senses (e.g., someone who is visually impaired identifying a perpetrator through the use of smell or touch versus sight which is traditionally used in the judicial system). Perez (1993: 29) also notes the reluctance of legal authorities to press charges due to the belief that "disabled women are too fragile to go through the legal system."

This myth is largely based on male definitions of sexuality and who is to be considered an appropriate and desirable sexual partner. If women with disabilities cannot be viewed as potential sexual partners, then they must not be sexual beings. Therefore, sexual abuse may not be recognized as such, or women reporting it may not be believed. A common alternative to this myth is that women with disabilities may be seen as sexually promiscuous and therefore dangerous. In this case, they require restrictions and control (Wolfensberger, 1975).

4) *People with disabilities are less than human.* Not only are people with disabilities viewed as less than human, but they begin to be seen as deserving of sub-human or animalistic treatment (Wolfensberger and Thomas, 1983; Senn, 1988). Waxman (1991) goes as far as describing this treatment as the result of hatred for people

with disabilities, largely fueled by seeing them as "less than human." This myth also relates to the objectification of people with disabilities, such that they become seen as objects that we either do things for or to. Dehumanizing attitudes reduce inhibitions against violence and thereby increase abuse (Sobsey and Mansell, 1990).

As with several of the other beliefs, this results in power and control not being afforded to people with disabilities. The use of language in ways that are dehumanizing, such as referring to people as their disability (e.g., the blind or the cripple), not speaking directly to people with disabilities (e.g., "what does she want to eat?"), or using animal imagery to describe people (e.g., as wild animals needing to be locked up) leads people to believe that individuals with disabilities do not have feelings or basic human desires. Wolfensberger (1975, 1992) described the portrayal in some cultures of people with disabilities as menaces, devils or animals. Behaviour which is socially defined as inappropriate, such as outbursts, salivating and spasms, may be interpreted as further evidence of being sub-human.

This is similar to the objectification of women generally as sex objects. This process removes a woman's individuality and, in doing so, somehow justifies or legitimates inhumane treatment. For example, the rape or other mistreatment of prostitutes, who may be perceived as the ultimate in sexual objectification, is often viewed as justifiable, as they somehow cease to be persons. This too, then, helps create an environment where abuse can occur or makes it

difficult to deal with, as occurrences somehow get explained away as something other than abuse.

5) People with disabilities are a menace and dangerous to others. Wolfensberger and Thomas (1983) discuss this myth and the implications for how people with disabilities are treated. This view suggests that physical control and brutalization are a necessary reality. Therefore, controlling methodologies and treatments, such as the use of physical restraints, segregation in separate institutions, etc., are viewed as essential and necessary, rather than abusive. Behaviours which serve to control are seen as in the best interests of both the public and the person.

In sum, *People with disabilities are different and therefore ought to be treated differently than "us."* This refers to some basic difference existing between people with disabilities and the rest of "normal" society. Such differences have been used to justify segregation and institutionalization (Wolfensberger, 1975). Such differences and stratifications also lead to what Wolfensberger (1992) refers to as "deathmaking." Deathmaking can be facilitated by institutional living and other separations. Institutional living has been justified both to protect people with disabilities and to provide the "necessary" specialized medical and educational services required by people with disabilities (Senn, 1988). These practices have served to keep people with disabilities separate, and have led to an acceptance by many members of the general public of what are sometimes bizarre treatment methods and social behaviours. Examples of these practices include segregation, incarceration in

institutions with poor conditions, non-medical sterilization (i.e., women need hysterectomies to prevent childbearing of "incompetents" or to "save their lives"), selective reproduction, mercy-killing/infanticide, sheltered workshop "slavery," medical experimentation, excessive use of restraints, torture, etc. (Scheerenberger, 1983; Wolfensberger and Thomas, 1983; Wolfensberger, 1992). Some of these activities have been defined as "eugenocide" by Wolfensberger (1981), drawing attention to attempts to eliminate disabled people. Israel and McPherson (1983) believe that people with disabilities act as a reminder of the fallibility of science and medicine, which is a very scary thought for most individuals. Waxman (1991) suggests that the attitudes which are behind such abuses really are symbols of deeper fear and hatred. In the same way, individual abuse sometimes becomes normalized based on the victim having a disability.

These differences are based on the socially constructed hierarchy referred to earlier which preserves the interests of the dominant (i.e., white, male, non-disabled, etc.) order. Rather than valuing diversity, differences become the sources of discrimination and prejudice, in need of social control and oppression (Wolfensberger, 1975, 1992). Wolfensberger (1992:5) states that people are most likely to be devalued when they are, among other things, seen as looking or acting different, or they are "perceived of as burdensome and demanding to a disproportionate degree." Differential treatment then becomes justified and, to a certain degree, accepted. This is similar to racism, whereby the

ghettoization of aboriginal people is justified, or to heterosexism which is sometimes used to justify homophobic behaviour.

The underlying belief that differences must be eradicated because they are undesirable is also a factor in how new reproductive technologies are viewed by people with disabilities. New reproductive technologies, and decisions about who should live or not live, makes statements about the basic value of people with disabilities. Wolfensberger (1975, 1992) discusses the view of people with intellectual disabilities as a menace to society as being rooted in the societal reactions of fear and distrust of anything unknown or unfamiliar. Rather than embrace diversity, differences initiate a need to control and eliminate in order to be comfortable and in control. When you don't see yourself reflected in mainstream society, you may come to be seen (or feel) abnormal.

The acceptance of negative treatment based on victim characteristics is part of a victim-blaming philosophy (Ryan, 1971). Victim-blaming emphasizes the differences of a victim and minimizes the similarities so that abuses are accepted as the result of those differences as opposed to the result of deliberate acts on the part of a perpetrator. A recent case of this occurred in Saskatchewan, where Robert Latimer killed his twelve year old daughter Tracy in what came to be viewed as a mercy killing as opposed to an act of murder. The law should not be selectively applied depending upon who the victim was or characteristics of the victim. In the case of people with disabilities, abuse may be labeled as "treatment" or as acceptable (or at very least understandable) due

to a "dependency stress model of abuse," whereby abuse occurs as a result of the increased stress on family/caregivers associated with the abused person's disability (Sobsey, 1990). Another example of this is the lengths to which people construct scenarios to explain how the (abused) individual came to misunderstand or misinterpret the actions of the caregiver (Perez, 1993).

The Dependency Stress Model of Abuse (Steinmetz, 1983) or Frustration Model of Abuse (Westcott, 1991) explains the abuse of people with disabilities or elderly parents being cared for by middle-aged children as due to an increased dependency on family caregivers and an inability to cope with these increased needs. Wolfensberger (1992) notes the inevitable devaluation of the person who most needs assistance. Browne, Connors and Stern (1985:129) relate that the "family system can quickly become overwhelmed and exhausted" and that individuals with disabilities "often become the scapegoats for an already exhausted and strained family system, bearing the burdens of the family's frustrations and resentments." Abuse, according to these related postulations, is a response to the increased stress, which in fact works to reduce the stress for a period of time. This type of model is limited in that it is victim-blaming (i.e., the abuse was somehow justified by the stress of caring for a dependent person) and does not fit with empirical research (Sobsey and Varnhagen, 1988).

Although these beliefs and myths are experienced by both women and men with disabilities, they may be more active in the realities of women. Since women generally are socialized to be

more passive, submissive and childlike (Ridington, 1989a; Perez, 1993), the negative effects are enhanced for women with disabilities, and women are disproportionately devalued--even in relation to men with disabilities. These conceptualizations result in powerful interactions. These myths contribute to vulnerability because they are held by people generally and are also internalized by the victims. Therefore, not only does the maltreatment happen, but it becomes viewed by the victims as being their fault, not hurtful, and so on.

2.5 BIOLOGY VS SOCIAL FACTORS

Oliver (1983) describes a social model of disability, and argues that it is the "handicapping" effects of a society geared to an able-bodied norm which "disables" far more than a person's mental or physical impairment. This is similar to the aforementioned differences between disability, handicap and impairment noted in the World Health Organization definition of disability. According to Oliver, the disabling is socially constructed and the resultant experiences of disability are that people with disabilities, by virtue of being in that class, experience oppression. This social experience is one of stigma and discrimination (Lloyd, 1992).

In a similar way, Scott (1969) argues that the process of becoming a 'blind person' is a social one, involving an extensive labelling process. "Blind [wo]men are not born, they are made" (p. 81). Blindness is but one example -- other disabilities in our society seem to follow a similar pattern. For example, a definition

of disability entitles the person to special services, such as rehabilitation services, pensions, or tax credits. Also, Scott notes that the labelling process is such that a fairly diverse group (in terms of actual biological disability) comes to be seen as a homogeneous group with attributes resulting from their common experience of being "disabled." In addition, there are a number of stereotypes which, through reinforcement by professionals and others, become self-fulfilling. Notably, pressure to accept the professional definition of the situation is very strong, and an important aspect of this is the strong influence of professional attitudes and beliefs in the lives of people with disabilities.

However, this purely social model of disability, based largely on socio-economic factors and the medicalization of disability, has been constructed by and for men with disabilities, and does not account for differences between men and women with disabilities. That there are differences is unarguable. For example, Lonsdale (1990) discovered higher numbers of women with disabilities in unskilled, menial work than either men with disabilities or non-disabled women. Women in this study, as well as those in other studies (Morris, 1989; Lonsdale, 1990), feel that there are significant differences in the education of men and women with disabilities. Hence it is important to consider gender differences when theorizing a social model of disability.

Both groups are subject to gender stereotyping, but the effects go in somewhat opposite directions. According to the stereotyping, even today, men are supposed to be independent, strong, and good

providers. Women are still supposed to stay at home and be nurturing and good homemakers. Due to educational, work, and other socio-economic disadvantages, women with disabilities tend to be financially in poorer positions (Lonsdale, 1990).

Another significant area of the social model of disability is related to the medicalization of disability. The model suggests that the medical model should be rejected for its narrow definition of disability as a biological/clinical condition, with resulting globalization of control over all areas of a "patient's" life. However, as noted by Webb (1986) and Lloyd (1992), it is women who have more significantly been affected by the influences of a male-dominated, individual-focused medicalization of their problems. The issues of medical devaluation, inappropriateness of "fixing" people with disabilities, limiting of choices, etc. described by women with disabilities (Lonsdale, 1990) are also experienced by women generally (Lloyd, 1992). However, the health care system occupies a more central role in the lives of many women with disabilities, perhaps increasing the degree of influence. Therefore, there may be a compounding effect.

Hanna and Rogovsky (1991) call this synergy the "female/disabled plus factor," whereby the oppression and disadvantages compound the effects of each other. For example, the discrimination of people with disabilities in the work sphere described by Lonsdale may be seen as magnified for women with disabilities. Also, many of these same issues of low pay, limited job opportunities, limited access to education, are issues for women

generally, but seem exacerbated by disability (Fine and Asch, 1981).

This compounding of disadvantage may lead to difficulties in identity. For example, Saxton and Howe (1987) talked to women who felt that disability was the primary problem in their lives, having greater significance than other inequities. They described this as a hierarchy of inequality, with disability as the most significant in their lives -- crossing the lines of gender, race, class, etc. It is not my task to discover which is the most significant, but it does present challenges for individual women in terms of which identity is strongest or most over-riding (Saxton and Howe, 1987). Therefore, what is needed is an approach that includes all significant aspects of identity to the greatest extent possible.

However, it should be noted that many women with disabilities are not aware of their situation as being in any way the result of oppression, whether it be based on sexism or ableism. There would need to be some first step, some raising of consciousness, like that ongoing in feminism, to achieve this state. Hannaford (1985:106) states that "disabled women will remain devalued until they themselves organize and thus raise consciousness and understanding of themselves as a devalued minority, and thus attempt to gain power and ultimately then lose disvalued status." Until this happens, the tendency to personalize and individualize their situations, such as noted during the ILRC women's peer support group on abuse (Andreychuk, 1993), is reinforced.

2.6 THE SOCIAL CONTEXT OF VIOLENCE AGAINST WOMEN WITH DISABILITIES

Walby (1990), in reviewing critiques of feminist theory, argues that the intersection of ethnicity and gender may alter ethnic and gender relations. The same can be said for the intersection of disability and gender. Not only do we need to account for the oppression and inequality based on disability, we also need to recognize that this inequality differs from that experienced by either non-disabled women or disabled men.

The risk of abuse is seen as anywhere from 1.5 to 10 times greater for disabled women as compared to non-disabled women (National Clearinghouse, 1993a). Studies which include both males and females with disabilities found that 75 to 80% of victims were females (e.g., Sobsey and Doe, 1991; Turk and Brown, 1992). I believe that the synergism between gender and disability creates a dimension which would not be present by considering either factor in isolation. Perez (1993:2) holds the same belief, as revealed in her statement that "Disabled women are significantly more stigmatized than disabled men, even more than sexism and able-ism would lead one to predict."

Therefore, in creating an analysis of women with disabilities in our society, one must consider the separate and interaction effects of sexism and ableism. Past attempts have focused on one factor or the other, which fails to account for the combined experience. What resulted was a situation in which women with disabilities felt excluded from the feminist movement, and negated

by the mainstream consumer (disability) movement. Yet women with disabilities are very much in need of a strong advocacy voice. Grothaus (1985: 125) contends that "disabled women have two threats to our civil rights, if not to our bodies: discrimination based on disability and discrimination based on sex."

The premise here is that violence against women with disabilities is a function both of the sexist and patriarchal nature of our society, as well as discrimination and prejudice rooted in ableism. I was unable to find a definition of ableism which is embodied in Canadian society's emphasis on the "perfect body" and image of what the ideal woman should look like.

The following definition is based loosely on definitional conceptualizations of homophobia and heterosexism (Worell and Remer, 1992). Ableism is the belief that being able-bodied (i.e., non-disabled) is inherently better or more "normal" than being disabled. People who are disabled, particularly women, confront the fears of those who are not disabled (Waxman, 1991). This is similar to Bogdan and Biklen's (1977) concept of "handicapism." They define "handicapism" as "a set of assumptions and practices that promote the differential and unequal treatment of people because of apparent or assumed physical, mental or behavioral differences" (p. 69). They (p. 69-70) believe that prejudice ("over-simplified and over-generalized beliefs about the characteristics of a group or category of people"), and stereotypes ("the specific content of the prejudice, used to justify particular treatment"), result in discrimination, or the "unfair and unequal treatment of individuals or groups".

Handicapism is evident at a systemic level as "services to [the] disabled people are considered a gift or privilege rather than a right" (p. 74).

Ableism is enacted and demonstrated by systemic and personal devaluation of disabled women. Ways this occurs include negative attitudes, exclusion, segregation, a focus on biological disability (while recognizing the gifts or other aspects of the person), and concentrating on making efforts to appear or return to normal (e.g., hiding invisible disabilities, models of rehabilitation, use of prosthesis, etc.), as well as the endless search for causes and cures (which devalues the condition of the person who has the disability). All of these represent attempts to make people with disabilities as much as possible like those who are non-disabled.

Ableism may be as pervasive as sexism, and socialization according to its teachings results in an expectation of less value, and the expectation that one will be discriminated against. The pervasiveness is such that prejudice and discrimination based on ability/disability is seen as "normal" or at least to be expected. This societal ableism, combined with the effects of sexism, may also be internalized by women with disabilities. Some effects of this may be low self-esteem, guilt, fear, and self-hatred.

Like the male norm within patriarchy, ableism purports a non-disabled norm. Not only is a non-disabled state seen as the norm, it is also held up as highly valued and "ideal." This ideal is then used -- by people of both genders, in most cultures, and of all classes -- as the basis for prejudice and discrimination. This occurs in much

the same way that differences from other "norms" are used against other minority groups, such as minority ethnic groups, lesbians and gays, etc. An overall hierarchy has been created which inordinately values the experience of male, white, Anglo-Saxon, Protestant, middle-class, non-disabled, heterosexual individuals. Other bases may be included from time to time dependent on the particular group or question. For example, within the general area of disability, the norm is a white, middle-class male with spinal cord injury. This group is the focus for most disability research, despite its relatively limited numbers (Asch and Fine, 1988). Characteristics that fall lower on or outside of this hierarchy are viewed as somehow deficient or "lesser."

Basic inequalities in one area often legitimate further mistreatment. For example, a person who is discriminated against on the basis of race or social class may feel justified in discriminating against someone who may be perceived as less powerful because they have a disability. Society is ordered according to this hierarchy or "pecking order" of discrimination. The more sources of difference an individual has, the lower she is likely to be on this pecking order -- and the more she is likely to be subject to discrimination from those above. For example, women of colour, despite their own oppression, may discriminate against other women or other groups which they perceive as possessing even more status. The more different the identities, in number and degree, the greater the number of bases for discrimination and, theoretically, the more intense the discrimination to be experienced.

Violence against women with disabilities occurs in a society which devalues both women and people with disabilities, and which some would say includes actual hatred. Waxman (1991) explores hatred as an unspoken and unacknowledged dimension in the abuse of people with disabilities. The reason it remains unacknowledged is that, in words anyway, outright hatred is an uncomfortable admission. It is far more comfortable, Waxman claims, to say one thing and do another. This includes a number of actions and practices that can be viewed in a context of hatred or, at very minimum, great disdain and fear. Wolfensberger also suggests that people may be unaware of their real feelings (Wolfensberger and Glenn, 1973; Wolfensberger and Thomas, 1983).

Dual Influences of Gender and Disability

How can we account for the dual influences of gender and disability? Standpoint epistemology (Hartsock,1983; and McCarl Nielsen 1990) provides a concept which may be useful in bridging the influences of gender (patriarchy) and disability (ableism). Standpoint, defined by Jaggar (1983, p. 382) is "a position in society from which certain features of reality come into prominence and from which others are obscured." Epistemology refers to a theory of knowledge (Lofland and Lofland, 1984, p. 11); in other words, a framework for explaining how we know what we know. Standpoint epistemology, then, is a way of knowing which is coloured by our position in society, particularly in relation to the positions of other groups.

Standpoint epistemology postulates that "less powerful

members of society have the potential for a more complete view of social reality than others, precisely because of their disadvantaged position" (McCarl Nielsen, 1990, p. 10). McCarl Nielsen sees this potential as deriving from the greater attentiveness of the subordinate group to the dominant perspective. This is referred to as double vision or consciousness, in which subordinate groups of people have the potential for "a knowledge, awareness of, and sensitivity to both the dominant world view of the society and their own minority perspective" (McCarl Nielsen, 1990, p. 10). This attentiveness, she says, is necessary for survival in the mainstream world. It is also important to note the *potential* nature of this sensitivity. In order to take advantage of the potential for double consciousness, the subordinate group must make an effort at awareness, and not just stick its collective head in the sand.

Due to differences in life experience and socialization (i.e., in what we experience and the roles and understandings we are given), members of a subordinate group are likely to see the world differently from the dominant group, and are more likely to see the world from their own perspective **and** that of the dominant group (Hartsock, 1983). The dominant group's view is seen as incomplete in comparison, because "it is in the [dominant group] members' interest to maintain, reinforce, and legitimate their own dominance and particular understanding of the world, regardless of how incomplete it may be" (McCarl Nielsen, 1990, p. 11). These vested interests fuel great efforts to maintain the status quo.

Women with disabilities have two attributes that place them

in positions of subordination. First, women's and men's perspectives are different and in opposition. Further, this difference is, according to Hartsock and McCarl Nielsen, inverted. Women, as the subordinate group, are therefore "more able to see the viewpoints of both men and women, and thus a woman's understanding is potentially more complete, deeper, and more complicated" (McCarl Nielsen, 1990, p. 24-25). Men, as the dominant group, through structures of patriarchy, work to maintain the current state of affairs. Many of them, having an incomplete view of reality, may not even be aware of the situation as experienced by many women.

The second source of difference comes from having a disability in a society which values a non-disabled state. Disability, similar to gender, offers a second source of deeper understanding. In terms of violence, those in the dominant position would certainly like to create the illusion that violence against people with disabilities does not exist. Within that, there are those within the disability movement who do not distinguish between violence and abuse experienced by disabled men and disabled women. Based on their unique vision or consciousness, women with disabilities are offered potential vision both by virtue of the subordinate position of gender, and also through the subordinate position of disability.

2.7 ABUSE AND WOMEN WITH DISABILITY

Womendez and Schneiderman (1991) state that all women, regardless of age, class, race and disability can be the target of abuse. Preliminary indications are that women and children with

disabilities may be among the most victimized groups in this country. Marcia Rioux (1990, p. 5), the Director of the Roeher Institute, a Canadian National Centre for research on issues related to people with intellectual impairments, states:

> We know that women and children are assaulted not because of their behaviour, but because they are perceived to be vulnerable. Similarly, people with disabilities are assaulted not because of their behaviour or because they are disabled, but because they too are perceived to be vulnerable by offenders seeking 'good victims'-- victims who, incidentally, they believe will not make credible witnesses in court.

Reasons for heightened vulnerability and victimization include the aforementioned myths, issues of self-image and low self-esteem, economic factors, negative attitudes toward women with disabilities, and risk factors connected to the specific disability (such as inability to communicate, etc.).

Offenders look for targets they perceive to be passive, easy to control, and vulnerable. Browne, Connors and Stern (1985:174) note that the social expectation for women with disabilities is to be "dependent, compliant and pitiful." Additionally, except for those with hidden disabilities, the physical vulnerability of women with disabilities is highly visible. Clarke-Drazen (1990:89) explains: "This visible vulnerability provides an increased opportunity for exploitation, not only from the expected source of random street crime, but from those in whom they are forced to place special trust [i.e., caregivers, family, etc.]." This is particularly important when one considers that rape and other abuses are often motivated by

domination, power and control, not sexual urges (MacLeod, 1987).

Women with disabilities also have the greatest distance from the "top" of the societal hierarchy (i.e., white, middle-class, non-disabled male). Women with disabilities who are of other than white racial or ethnic origin, or who are lesbian, become subject to further sources of negative valuing and discrimination, based on layers of identity disparity from this so-called "norm" (Traustadottir, Lutfiyya and Shoultz, 1994). This creates further layers of oppression, which may lead to further vulnerability. Similar to Appleby's position with regard to lesbian women, one does not want to suggest a hierarchy of oppression wherein one identity is more oppressed than another, but it is important to note the "fact that some identities are socially more powerful and more acceptable than others" (1994:28). This may not create experiences which are necessarily different, but one would suspect that the effects of oppression might be compounded.

Statistics on Abuse and/or Violence and Disability

Statistics on disability reveal that 14.7% of women in the general population have disabilities (Secretary of State, 1990). In "Beating the Odds," the DAWN Canada 1989 Research Report on Violence and Abuse of Women with Disabilities, 40% of survey respondents had been abused, raped or assaulted (Ridington, 1989b). This study, described earlier, included responses from 245 out of 1200 disabled women across Canada. Other significant results included: 64% of respondents had been verbally abused (due specifically to their disability); girls with disabilities have a less

than equal chance of escaping violence; and women with multiple disabilities are likely to be abused many times (Ridington, 1989b).

A few comments on these figures may shed some further light on their significance. Often verbal abuse is minimized and viewed as less harmful than other types of abuse or violence. However, for women with disabilities who may already have lower self-esteem than the "average" (i.e., non-disabled) woman, further verbal attacks may be devastating. This is even more the case when those verbal attacks are in the context of their disability (Barile, 1988).

The figure relating to girls with disabilities refers to a relationship between age at onset of disability and occurrence of violence. Ridington (1989b) reported that 53% of respondents who were disabled at birth or in early childhood had been raped, abused or assaulted. This was compared to the rate of 32% for those disabled later in life. The early onset relationship is significant and in need of further study, particularly as it impacts upon formation of identity and self-esteem during these early years. Ridington (1989b) reported that 56% of the cases of violence in her study had occurred after the onset of disability. Doucette (1986) found that 65% of the disabled women who reported abuse had been disabled at the time. The reasons for this need to be further explored.

The results on increased danger and vulnerability due to multiple disability are particularly frightening. Those women with more than one disability or with more severe disabilities were much more likely to experience abuse (Ridington, 1989b). Additionally, those with multiple disabilities also appeared to be more likely to

experience multiple incidents of abuse (Ridington, 1989b). This indicates that those whose disabilities might be most challenging, as well as those who might, therefore, be more dependent on others for assistance, were in the greatest amount of danger.

Others conducting research into abuse and disability report similar results. Barile (1988), reporting on survey research of women with disabilities in Quebec, found that out of 96 Quebec women, 23% had been beaten, 20% slapped, 13% shaken, 23% kicked, 23% physically abused, and 26% sexually abused. Barile also discovered that 66% of her respondents had been verbally abused.

Senn (1988) believes that people with intellectual impairments are at the greatest risk of abuse. Muccigrosso (1991) cites factors such as socialization to be trusting, a sheltered childhood, and obeying people in authority (compliance). Other groups, such as those who are mobility impaired, visually impaired or blind, deaf or hearing impaired are also noted as vulnerable, each in slightly different ways, but with many commonalities (Ridington, 1989b). One final group to mention is women with psychiatric disabilities. Jacobson and Richardson (1987) reported extremely high rates of sexual assault among women admitted for psychiatric hospitalization. They found that 81 out of every 100 women admitted had a history of major physical or sexual assault sometime prior to admission.

In terms of childhood abuse, Doucette (1986) discovered that more of the disabled respondents had been physically (67%) or sexually (46%) abused as children, compared to 34% of the non-

disabled respondents. Doucette's study was an important one in the sense that it included a control group of women without disabilities. Sobsey (1988) has also found that disabled girls are at much higher risk than non-disabled girls. He adds that girls are at a higher risk for childhood abuse than boys. Perez (1993) also notes this difference in vulnerability as she suggests a need to encourage the same level of independence and self-esteem for women with disabilities as their male counterparts.

2.8 VULNERABILITY TO ABUSE

All women are seen as vulnerable to abuse and violence, but there are a number of risk factors which have been identified in the literature as related to a higher vulnerability for women with disabilities. Doucette (1986) found that even while trying to match other characteristics, the rate of physical abuse was almost twice that for non-disabled women. The following factors might account for this greater vulnerability: education and employment, physical ability, credibility, life skills, helplessness/dependence, inaccessible services, and loss of services.

Education and Employment

Women with disabilities often live in extreme poverty and tend to lack high degrees of formal education. Benefield and Head (1984) note that women with disabilities receive less encouragement than disabled men or non-disabled women to achieve high levels of education or to continue their education. Benefield and Head also mention the differential association of disability and work by

gender, in that 60% of disabled males searching for employment find work versus 29% of disabled females (1984, p. 62). Education and employment have marked effects upon personal resources, self-esteem, and isolation. In combination, education and participation in employment provide valuable sources of information and support, which could provide resistance to abuse.

Physical Ability

Women with disabilities may find that their disability limits their ability to escape or fight back. Sobsey and Varnhagen (1989) discuss specific factors such as impaired motor skills, or an inability to defend oneself verbally or physically or to escape from an attack. As noted by Victims of Violence International (1990, p. 1):

> The disabled are more vulnerable to crimes of violence. They are relatively easy targets for those who would prey upon them. Furthermore, many disabled victims have very real concerns in reporting criminal attacks upon themselves. They fear the loss of services that are necessary for their survival. Some are even so handicapped that they cannot report the crime.

This points out actual physical difficulties in avoiding abuse and in reporting it. For example, a visually impaired woman may not notice the development of a potentially dangerous situation, such as being followed while walking down the street. Women who use wheelchairs may have difficulty escaping from a house which is not fully accessible. Womendez and Schneiderman (1991) discuss these and other unique issues to be considered for women with disabilities

escaping from abuse. Other factors include the limited knowledge about sexuality and limited opportunities to experience healthy sexuality and intimacy, and that regardless of how negative it may be, women with disabilities should be grateful for any sexual attention they receive (Womendez and Schneiderman, 1991).

Credibility

Women with disabilities are also seen as lacking credibility as witnesses (Hanna and Rogovsky, 1991), partially due to physical considerations, such as impaired memory, reliance on alternate forms of perception (e.g., testimony based on sounds and smells versus typical eye-witness accounts), or difficulty communicating. Difficulty communicating or impaired communication skills are viewed as contributing to increased risk also in terms of women being physically unable to report abuse (Sobsey and Varnhagen, 1988), or needing to rely on the abuser (in the case of an abusive caregiver) in order to call for help. Communication, particularly for those with speech impairments, may be made more difficult by frustration and and poor social skills (Sobsey and Varnhagen, 1988).

"People with disabilities are often seen as dependent on relatives, friends and caregivers for physical and/or emotional support, and as more vulnerable than those who appear not to be dependent on others" (Ontario Federation for Cerebral Palsy, undated). Senn (1988) also notes the lack of credibility and lack of investigation when the victim has a disability. In combination with negative stereotypes about women with disabilities, including a low social value, potential abusers may see them as "easy prey." Clarke-

Drazen (1990: 89) comments on this vulnerability by saying "They wear their disability like the proverbial scarlet letter, only in this case the letter is 'V' which stands for Victim." Not only are women with disabilities viewed as easy victims, but those who abuse them are not likely to be caught or prosecuted. The lack of official response would certainly indicate that the odds of not being detected or punished are good (Senn, 1988).

Life Skills

Lack of education about sex, and about their basic human rights also puts women with disabilities in compromising situations (Perez, 1993). Not knowing what is abuse and what is not increases their vulnerability (Muccigrosso, 1991). Muccigrosso also calls attention to the sheltered and isolated nature of their lives growing up, including restricted social and learning opportunities and lack of chances to develop personal power and control. Extremely low self-esteem may create an even more urgent need to be loved and accepted (Muccigrosso, 1991), which may have women with disabilities resort to accepting even negative attention. Although Muccigrosso was referring primarily to women with mental disabilities, this same pattern has been described by women with many other types of disabilities. More than other children, women with disabilities are taught to be compliant and passive (largely to make caregiving more convenient), and to have an abnormally high respect for authority, in contrast to the more active "streetproofing" given other children (Sobsey and Varnhagen, 1988). The lack of personal power, combined with segregation and

isolation, increases vulnerability.

Helplessness/Dependence

Learned helplessness and compliance also contribute to vulnerability (Sobsey and Varnhagen, 1991). This refers to women with disabilities feeling as though they have little to no control over events in their lives, as well as feeling overly reliant on other people for survival. Women with disabilities are also taught to be compliant with authority, even when it might put them in danger. Despite this inherent risk of danger, service providers and caregivers place a great deal of emphasis on ingraining this compliance, in order to make caregiving "easier" (Sobsey and Mansell, 1990). Perske (1991) also refers to the inordinate desire of many individuals with disabilities to please authority figures, combined with a lack of understanding of basic human rights, as contributing factors.

The dependence on caregivers also puts women with disabilities in potentially risky situations more often. Aside from those doing household duties, many of these caregivers, including those doing very intimate care procedures involving women with disabilities, are men. Perez (1993:6) states "It is surprisingly easy, with very little screening, for an undesirable person to become a personal care attendant or ambulette [ambulance]/van driver." Sobsey and Doe (1991, p. 246) found that most (90.8%) abusers were male, so setting up these situations behind closed doors can be viewed as a risk factor.

Sobsey and Varnhagen (1989) also mentioned the asymmetrical

nature of caregiving relationships, where the caregiver is usually in control, as a contributing factor. "Independent Living" philosophies, based on principles of consumer control and empowerment, aim to reduce some of this disparity. Other features of that caregiving relationship, such as the use of physical restraints, tranquilizing or controlling drugs, etc., may also lower defenses to abuse.

Inaccessible Services

Even if women with disabilities were to report or try and escape their situations, many services in the community are inaccessible. Masuda and Ridington (1990), researching the accessibility of women's transition houses (shelters for battered women) and crisis centres across Canada, discovered that most were inaccessible to women with a variety of disabilities. This included architectural lack of mobility or wheelchair access, no TTY's (for women who are hearing impaired, deaf, or with communication impairments), and an inability to provide other necessary accommodations, such as sign language interpretation, braille, tape or large print materials (for women who are blind, visually impaired, or illiterate), attendant care, or the confidence and willingness to deal with women with particular disabilities such as psychiatric disabilities and women labelled mentally handicapped. (The specific situation in Winnipeg will be discussed in a later section of the thesis.)

Loss of Services

In addition to these physical considerations, Womendez and Schneiderman (1991) point out the importance of social

considerations, such as lack of validation and fear of loss of services. In addition to other difficulties, women with disabilities run a very high risk of not being believed, particularly when it is their word against a more respected, male perpetrator. They also risk losing the very services which allow them to remain independent in the community (Perez, 1993). Doucette (1986), for example, reported that women with disabilities do not report sexual abuse when perpetrated by caregivers or other professionals or family members due to the fear of service withdrawal or interruption, or fear of being stranded. This is a major consideration, particularly when the only service alternative might be a personal care home, even if the woman is only 30 years of age. Similar situations exist with other systems, such as the transportation system, when there are no readily available alternatives. It is like having a captive audience when people have no choice and little control.

In addition to all of these factors, women with disabilities tend to have lower than average self-esteem, and self-esteem appears to be strongly related to abuse victimization. Partly this may be because abusers feel that in these cases, they can get away with the abuse. Whether or not this is a causal relationship is not within the purview of this thesis, but the literature would suggest a strong correlation. As will be discussed later, some of the women comment on their perceptions regarding this in their interviews, particularly when asked about whether or not they saw a relationship between the abuse and their disabilities.

2.9 SELF-IMAGE/SELF-ESTEEM

This section describes the context within which women with disabilities experience abuse. I then begin to examine the effects of early versus late onset disability.

Self-image can be viewed as how we see ourselves and self-esteem can be defined as how we feel about ourselves. These concepts are inextricably tied to each other. For women generally, body image is a predominant influence on self-image. Body image, or beliefs about how one appears to others, as well as intellectual ability, often gets translated into feelings of self-worth. Edwards (1987) explains that women have been taught to link how they see themselves and how they feel about themselves.

Women are led to this preoccupation with appearance and imaging based on "ideal" beliefs about body size, physical attractiveness, and other physical traits. Hall (1992) refers to this as the "beauty quest." This mythical ideal is difficult for most women to approximate; it is next to impossible for most women with disabilities to look like this unrealistic ideal. Hall remarks that women with disabilities cannot even disguise or otherwise change their appearance to the degree necessary to fit the cultural ideals for women.

> We cannot diet away our disabilities or cover a disfigured face with make-up, or disguise an epileptic seizure. We cannot wear our ill-fitting clothes with panache when our disability gives us a drunken appearance. We are not contenders in the beauty stakes. Our disabilities have made us outcasts from womanhood (Hall, 1992, p. 137).

This quote refers to the impossible task many women with disabilities have in achieving cultural ideals set for women in Canadian society. Not only are women with disabilities limited in the degree to which they can change this reality, but this reality, one in which their appearances do look different, is often the basis of prejudice and discrimination. Perez (1993: 3) reports that "Unattractiveness and disability are equated. In a survey, it was found that the concept 'woman' is often linked with beauty whereas 'disabled woman' evokes associations of ugly and unpleasant." Although we are told differently, it is the case that people are judged on how they look rather than on the basis of abilities or personalities.

Lonsdale (1990) believes that women with disabilities are equally likely to be influenced by the predominant beliefs about "ideals of attractiveness," regardless of the time of the onset of their disability. She suggests that the further they are from the perceived ideal, the more likely it is that their self-image will suffer. In other words, even with an invisible disability, if she believes that she is very different from the ideal, she may be more likely to have a negative self-image. One wonders, however, if at some point of great departure, women with disabilities can begin to no longer care about reaching these "ideals." This might be a solution advocated by radical feminists or others who suggest no longer trying to "buy into" a system which is not representative of the needs or realities of the group in question.

Factors Related to Poor Self-Image

Other factors that are related to negative self-image include negative reactions from others, lack of control over "normal" adult body functions, incorporation of "hard" items (such as braces, wheelchairs, etc.) into the vision of feminine "softness," and (justifiable) fears of rejection socially and sexually (Lonsdale, 1990). Negative reactions from others refers to the kinds of attitudinal phrases that are heard all too often, in terms of obvious reactions, such as "that is just so gross," to the more subtle yet equally distressing statements like "she was so talented [before the accident]." Incontinence, spasticity, and lack of social skills are all seen as unacceptable adult behaviour, and therefore lead to negative attitudes by others, yet these may be aspects of a person's disability which are beyond control (or may only be controlled through risky or invasive procedures or products).

Finally, the reality is that people with disabilities, particularly women, are subject to discrimination socially, and are not generally viewed as attractive sexual partners. Ferguson Matthews (1983, p. 126) says that "Disabled people find themselves reeling from painful slurs far more often than the able-bodied (racial minorities excepted)." This, she notes, may come from words and actions directly aimed at them, but also in more indirect ways. "From the onset of any disability, a person has to learn to deal with the curiosity of the able-bodied" (Ferguson Matthews, 1983, p. 134).

Self-Esteem and Onset of Disability

Ferguson Matthews (1985, p. 48) states that women born with

disabilities face "even greater, more complex difficulties" than those women disabled as adults. This, she says, is the result of greater problems of self-esteem and lack of self-confidence. Asch and Fine (1988) and Browne, Connors and Stern (1985) emphasize the problem that children with disabilities have few role models to emulate, and they also lack positive reinforcement from parents or caregivers. These factors, they say, result in low expectations for self. Browne, Connors and Stern (1985, p. 130) stress the importance of "the opportunity to associate with other disabled children and adults in atmospheres that foster our individual growth and the incorporation of our disabilities into positive self-concepts." Yet it is most often the case that for those born with disabilities or disabled at an early age, opportunities for association and role models are lacking.

Stimpson and Best (1991, p. 58) note the reverse side of the coin from Ferguson Matthews, that when a woman becomes disabled as an adult, "she will be rudely struck by the realization that much of her self-image has been based on able-bodied concepts and values. She will have to learn to adapt to a new image of herself which will include an acceptance of her disability." Israel and McPherson (1983) believe there is an advantage for those who become disabled in early adulthood (versus being born with a disability), in that they know what it's like to live in the community and take part in its activities, and therefore have more reason to struggle against institutionalization, over-protection and dependency. Israel and McPherson suggest that "those disabled from birth or at an early age

are all too often segregated from the community" (p. 17). In either instance, self-image is greatly influenced by disability.

Importance of Self-Esteem

DAWN Canada suggests that self-esteem and self-image are among the most important issues facing women with disabilities. Research conducted by DAWN during 1988 (reported on in 1989) included a significant interest in questions of self-image among women with disabilities. That research, based on survey responses from 245 women with disabilities across Canada, explored issues related to how "women who are born with disabilities, or develop them later in life, imagine their own strengths, learn to love themselves and others, and express their full potential?" (Ridington, 1989a, p. 1). In the founding meeting and initial national survey project, self-image was ranked as the most important concern for participating women with disabilities. Ridington notes that a strong self-image is intrinsically tied to other areas of life, including an impact on employment, relationships, parenting and resisting violence (Ridington, 1989a).

Although differences between disabled and non-disabled people are an important factor, one cannot ignore the internal ordering of disability which also exists. Thompson (1985, p. 82-3) refers to people being ranked according to the degree of acceptability of their disability:

> An individual's position in this hierarchy is generally determined by how well that person fits into society's "norm." In other words, the less disabled you look, the higher your rank.

This ranking system, based on assumptions regarding the so-called "acceptability" of how one looks and acts, is used both internally by the disabled community, and also by the non-disabled community. Browne, Connors and Stern (1985) concur and point to how strategies are developed to moderate/balance off the reality that large parts of themselves are seen as unacceptable to those around. They say that "Sometimes it is safer to withdraw from interaction with others than disclose our vulnerabilities to a hostile audience. At other times we may choose to interact, but pass ourselves off as able-bodied" (p. 173). Pressure to conform is very great and comes from a number of different sources. The values by which the rankings are made reflect those of the larger society, including its patriarchal and ableist biases.

Related Factors

Psychological and verbal abuse, resulting in feelings of worthlessness, were also common factors reported by the women in the survey, as was the threat of being abandoned or sent away to an institution or special school (Ridington, 1989a). Emotional neglect was also cited as a barrier to the development of positive self-esteem.

Education, and its relation to later financial and social effects, was also discussed as having an impact on the self-esteem of the women in the study. "Lack of information and skills that are common for most people can be devastating on self-esteem" (Ridington, 1989a, p. 18). She also notes that those born with a disability or those who become disabled in childhood are less likely

to achieve even a high school education. For those who have gone to school, there are issues of isolation and lack of social opportunities for those in segregated schools, and scars of ridicule (based on difference) for those in mainstream schools (Ridington, 1989a).

Other important aspects related to education refer to the knowledge often denied to women with disabilities. For example, due to a lack of respect by the medical profession, women with disabilities are often "denied our right to know what is wrong with us. We may not be consulted about medication and treatment" (Ridington, 1989a, p. 21). Not only is the confidence of women with disabilities undermined, but women continue to be treated as if they are their disabilities. In other words, the women are not viewed as whole and functioning individuals who have other needs, concerns and attributes outside of their disabilities. The central focus is on their disability, rather than on other aspects of their being. This also has a negative effect on self-esteem and self-worth.

Ridington discusses the difficulty with relationships experienced by many women with disabilities. This includes both difficulties with friendships and intimate relationships, which were listed as common answers when asked about where they gained strength and support. Barriers to relationships include physical ones, such as limited ability to get around or communicate, as well as psychological and social ones, such as lack of self-confidence, personal vulnerability and fear of violence (Ridington, 1989a, p. 25).

Not only are relationships and social networks difficult to form, but many end when a woman becomes disabled. In the

Ridington study, 34% of the women who became disabled after childhood had a change in their relationships after the onset of their disability. Forty-three percent of the women were single and 22% were married (Ridington, 1989a).

Finally, in addition to the poverty that shapes the lives of many women with disabilities, including a great impact on their access to clothes and other sources of positive appearances, is the image of media portrayals. Ridington notes the difficulty of feeling good about oneself when the media portrays imagery of vulnerability, incompetence, pity, and being crippled and objects of charity -- all of which adversely affect self-esteem. Bogdan and Biklen (1977) concur and say that the "mass media present prejudicial and stereotypical images of the handicapped" (p. 71). The images they note range from dumb, stupid, violent, hated, helpless, dependent, needing charity, and childlike. Browne, Connors and Stern (1985: 173) reveal that women with disabilities "may internalize negative attitudes about ourselves and feel ashamed and embarrassed about being disabled." Thoughtless, derogatory and insulting language was also viewed as having a negative impact on self-esteem and self-worth.

2.10 EARLY VERSUS LATE ONSET DISABILITY

It is important to look a little further at early versus late onset of disability. The importance of this distinction to this thesis rests on the degree to which women with disabilities had been primarily socialized to the role of living "with a disability" and/or

"become disabled." In the same way that female infants are socialized into a culture that treats women as "denigrated, undervalued, and organized around absence and lack," infants with disabilities also become subject to early experiences which form the basis of definitions of who they are (Harris and Wideman, 1988, p. 115). Browne, Connors and Stern (1985: 129) declare that "For those of us disabled as children, our disabilities have profoundly affected those early life experiences."

Early Onset Disabilities

Harris and Wideman (1988) note that one of the earliest examples of socialization regarding disability is the lack of rituals and celebration associated with the birth of a baby who has a disability. Such a birth may actually create withdrawal, silence and crisis (Ridington, 1989a). Often these births are met with "grief, sadness, hatred, depression, and hope [i.e., that this disability will only be temporary]" (Harris and Wideman, 1988, p. 119). These feelings may come to be internalized by the child in the process of growing up and developing self-identity.

Growing up with a disability also means needing to incorporate the social meaning of disability into one's identity. If, as in Canadian culture, the social meanings of disability tend to be negative and discriminatory (Benefield and Head, 1984), it would follow that self-esteem and self-identity would be affected in a negative way. Benjamin (1987) notes the importance of positive recognition and affirmation from early caregivers in the development of a healthy identity. Yet many barriers stand in the

way of young children, particularly girls, with disabilities receiving such unconditional love and recognition. Some of these relate to being female, but most relate to having a disability.

Ridington (1989a) and Harris and Wideman (1988) also make mention of the dimension of severity of disability. Normally, children growing up progressively learn to become somewhat distinct and autonomous individuals. However, Ridington (1989a, p. 6) notes that "If her disability is severe and other supports in the community negligible, she is forced to recognize that she will never be completely autonomous." A focus on disability may also result in over-protection and greater dependency, which also means fewer opportunities for independence, social interaction, and personal power and control. Due in part to the lack of access to role models of adults with disabilities, "parents naturally have few images of how their children could grow up to be functioning adults in society's mainstream. It may seem best to protect us from the outside world and teach us to be dependent on the family" (Browne, Connors and Stern, 1985, p. 130). This situation is changing, but ever so slowly. Browne et al. (1985, p. 129) also convey that "Caring for a disability may be so time consuming that there is little energy left for caring for the child." This aspect may be dependent on the resources at the disposal of the family as well as the severity of disability. Parents may not have the energy or optimism to give their daughters the confidence and self-esteem they require.

Ferguson Matthews (1985, p. 48) also mentions that those women born with disabilities often have not developed the social

and communication skills often learned in early childhood, due to limited opportunities and segregation. A child with a disability may receive other related messages that also diminish self-esteem, and make the formation of a positive identity difficult. Examples include being seen as unattractive, feeling that other children will make fun of her and that no one will ever want her (as a friend or a partner). The significance of this is revealed by Ferguson Matthews (1985, p. 49). She writes: "those who learn the value of self-esteem are those who have always had the unwavering support of those closest to them. Women who have been ignored by their families, treated as problems, neuters, burdens, appear to blossom into self-confident adults only rarely." She may also be told that she is forever in need of protection, even to the point of not being allowed the opportunities to play with other children (Ridington, 1989a) or to belong to a peer group (Ferguson Matthews, 1985).

Late Onset Disabilities

We see, therefore, that early onset disability has major effects on self-esteem and identity. Late onset disability has effects of its own, which may be different than the experiences of women who have lived with disability as part of their identity for many years (and vice versa). For example, the late onset of a disability may be met with anger, despair, and non-acceptance. In fact, Thompson (1985, p. 81) refers to the "out of control anger and frustration experienced by newly disabled women," which may come into conflict with the [perceived] complacency of women who have accepted their disabilities. On the other hand, Ridington (1989a, p.

45) says that "Women who are disabled as adults often express frustration with women who have been born disabled, because many of them have so many unmet needs, many are ignorant of the feminist movement, many have an extremely poor self-image, many lack education and experience."

Ridington, 1989a (p. 24) writes of differences onset by saying:

> While women born with disabilities may have difficulty seeing themselves as adults worthy of respect and caring, women who become disabled in early adulthood have trouble adjusting to a body they can no longer rely on. Where they have established an identity built on skills that are lost to them, the adjustment can be extremely difficult.

Clearly, women with disabilities experience difficulty regardless of the age of onset of disability, but for different reasons.

This represents only a brief introduction to the differences and experiences between early and late onset disability. This dimension will be utilized in the analysis as a way of looking at the effect of primary identity while growing up as disabled or not in the later experiences of abuse.

2.11 EFFECTS OF VIOLENCE AND ABUSE ON IDENTITY

Ridington (1989a, p. 11) emphasized the clear role of abuse and self-esteem:

> Abuse -- whether sexual, physical or verbal, or in the form of neglect -- has a debilitating effect on self-esteem. ... Childhood abuse leads to lifelong vulnerability. Women come to accept the verdict that they are worthless. We become the targets for more abuse.

Sixty-four percent of the DAWN Canada respondents had been verbally abused because of their disability. Ridington (1989a, p. 14) also says that "abuse is more common among girls and women who were born with a disability or who became disabled early in life." Of those disabled at birth or early childhood, 53% had experienced violence or abuse. This compared to 32% of those whose onset of disability was over 10 years ago or 5-10 years ago. She felt that reasons for this included putting up with more abuse due to fears of being institutionalized, fears of family breakdown, and mostly, fears of not being believed (partially due to poor self-esteem).

Masuda and Ridington (1990, p. 15) note that "sexual abuse in early childhood colours our lives, our sexuality, and our self-image." The literature illustrates a cycle in which abuse leads to a lack of self-confidence and self-respect, leading to vulnerability and becoming the target of more abuse. Ridington (1989a) also writes about a strong relationship between self-image and the frequency of incest and sexual abuse by male relatives and caregivers.

Although a major problem for women generally, low self-image or self-esteem is particularly problematic for women with disabilities. The literature illustrates a cycle in which women with disabilities have difficulty with low self-esteem, which increases vulnerability to abuse or makes it more difficult to escape from it, and abuse leads to a lack of self-confidence and self-respect, leading to further vulnerability and to further victimization, and so on, in a vicious cycle. Where this cycle starts and stops is unknown,

as is any causal connection. Battering/abuse lowers self-esteem. Disability in our society also lowers self-esteem. Therefore, women with disabilities who experience abuse and violence may be seen as being doubly at-risk.

Abuse, like patriarchy, serves to silence women. Sexual abuse, for example, confirms feelings of shame and lack of self-worth. These in turn further silence women. Other effects of abuse include difficulty trusting, physical harm, alienation from oneself and others, anger and guilt, revictimization, and for some women with disabilities, loss of essential services (such as personal care, transportation, etc.), including, ultimately, loss of independence. All of these, directly or indirectly, contribute to the silence of women with disabilities.

The literature shows that the problem of the abuse of women with disabilities is significant, yet has not been well studied. The problem has been viewed largely as an individual phenomenon, rather than the social problem which it is. This review looked at what has been found by the Canadian Panel which examined violence against women, and by the research done by the DisAbled Women's Network of Canada. The abuse of women with disabilities has been found to occur at a rate of 1.5 to 10 times that for non-disabled women. The literature also provided information on the major sources of vulnerability to abuse experienced by women with disabilities. The effects of abuse and violence on the self-image, self-esteem and identity of women with disabilities was also explored. Finally, the

dimension of early and late onset disability was introduced.

In an attempt to begin to formulate a more systematic approach to the problem of the abuse of women with disabilities, I move from this literature to consider the broader literature on violence against women. I will use this broader literature to form a conceptual framework for analyzing the abuse of women with disabilities.

CHAPTER THREE: CONCEPTUAL FRAMEWORK

3.1 INTRODUCTION

This is an exploratory study examining the experience of abuse among women with disabilities. As noted in the previous chapter, there has been a limited amount of research on women with disabilities and the subject of abuse. Even less work has been of a theoretical nature.

Some feminist theorists and researchers have begun to systematize our understanding of abuse. The frameworks that have been articulated, while not focussed on women with disabilities, have relevance to this study. Accordingly, in this chapter, I outline the underlying concepts and assumptions that guide this study, drawing upon the contributions of feminist research on abuse. A conceptual framework is presented, which delineates the salient factors that predispose women to abuse and violence.

3.2 A FEMINIST PERSPECTIVE

Feminism can be seen as a range of theories that describe and explain women's oppression, and suggest strategies for liberation or change (Tong, 1989). Although there are differences in the various currents of feminism, there are a number of commonalities. Jaggar (1983, p. 6) refers to the dynamic nature of oppression, and puts forward the belief that "the problem [oppression] is not the result of bad luck, ignorance or prejudice but is caused rather by one group actively subordinating another group to its own interest." Women's

oppression therefore is not just a "naturally occurring" phenomenon. It can be seen as a deliberate attempt to maintain (male) dominance.

Feminism has also been described as "a politics directed at changing existing power relations between women and men in society" (Weedon, 1987, p. 1). Most feminist conceptualizations perceive "the personal as political," and this is viewed as a potential site for change. Laws (1986: 58) defines feminism as a "belief that women are oppressed and a commitment to end the oppression." Feminism is by definition directed at examining the oppression of women, with the goal of eliminating this oppression. In this sense, feminism (and the personal experience of women) is indeed political.

Feminist perspectives are key in the study of violence against women. Because of feminist research, violence against women is now identified as a significant social problem (Thorne-Finch, 1992). Until recently, psychological theories of abuse which suggest that abuse results solely from psychological abnormalities or mental illness were dominant in this field (Bograd, 1988). Feminist approaches questioned the assumption that violence was natural or inevitable, and that it could be accounted for in psychological terms alone.

A feminist perspective suggests that we must situate abuse and violence in a larger context of a patriarchal society, which has an unequal distribution of power, and patterns of male/female relations that are socially structured and culturally maintained. This represents a major paradigm shift from abuse and violence as psychopathology. This, in turn, influences the way in which we feel

the problem can be managed, suggesting institutional and societal interventions rather than purely individual ones.

My conceptual framework is situated against a backdrop of patriarchy, along with sexism and the oppression of women. Our society is structured along the dimension of gender -- men as a class hold power over women; women are devalued as secondary and inferior (Bograd, 1988). Thorne-Finch (1992:53) states that:

> We live in a culture that is predicated upon the subjugation of women by men. ...through the creation and perpetration of a complex system of ideas, values, customs, and institutions, men have been able to obtain and maintain power over women.

A central concept to consider in our culture is patriarchy, which allows and fuels sexism and the oppression of women.

3.2.1 PATRIARCHY

Central to a feminist discussion of gender relations and violence is the concept of patriarchy, which has been defined as:

> The manifestation and institutionalization of male dominance over women and children in the family and the extension of male dominance over women in society in general. It implies that men hold power in all the important institutions in society and that women are deprived access to such power (Lerner, 1986, p. 239).

Patriarchy is a total system of domination (Millett, 1970; Jaggar, 1983). Most feminists do agree that the oppression of women is the most longstanding, widespread and deepest form of human oppression (Tong, 1989; Daly, 1978). Patriarchy is the pervasive,

systematic and historical domination by men as a group over women which results in the oppression of women in many areas of life. Sexual domination is so universal and complete that it appears "natural," and also becomes invisible. It may be "the most pervasive ideology of our culture and provides its most fundamental concept of power" (Millett, 1970, p. 25). Weedon (1987: 2) states that "In patriarchal discourse the nature and role of women are defined in relation to a norm which is male." In order to sustain itself, "Male violence is seen as relying on the suppression of the feminine, which may take many forms, for example, the suppression of lesbianism, the male definition of female sexuality" (Weedon, 1987, p.7).

Further to this, Tong (1989) adds that "Male violence against women is normalized and legitimized in sexual practices through the assumption that when it comes to sex, men are by nature aggressive and dominant, whereas women are by nature passive and submissive" (p. 110). This essentialist assumption, that there are basic and inherent differences, based in biology, between men and women which make them the "way they are," although not true, is treated as true in order to preserve the status quo and male domination over females. Patriarchal society is a social construct, based on meanings given to differences originally based on biology, although it is defended as being naturally occurring and legitimate.

According to feminist theory, violence against women is not an individual phenomenon. Instead it is the result of gender inequalities based in an historically patriarchal and sexist society. Radical feminists view women's oppression as due to the patriarchal

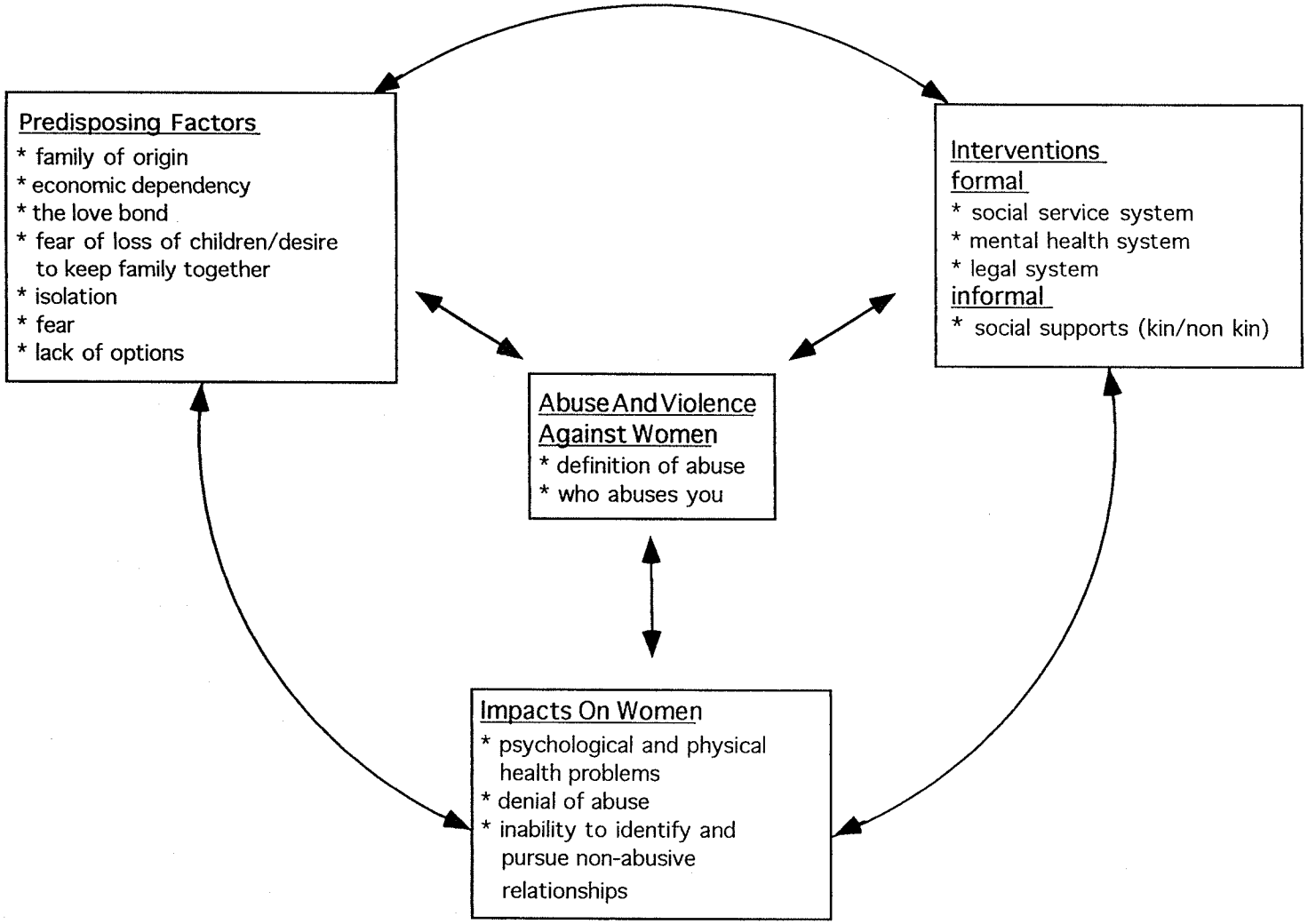
system characterized by power, dominance, hierarchy and competition (Tong, 1989). The basic structures of our society are seen to condone and support violence against women (Lerner, 1986). This violence as well as the supporting structures become unspoken, unchallenged and viewed as natural or "the way things are," and therefore not subject to human (especially female) change or control.

3.3 THE CONCEPTUAL FRAMEWORK

Figure One (p. 73) represents a conceptual framework which is used in understanding violence and abuse against women. The applicability of this framework to understanding violence and abuse against women with disabilities is the primary focus of this study. The included variables or features have been drawn from the literature as important factors involved in family violence and the dynamics of wife battering.

The relationships depicted in Figure One are not intended as causal, but rather show the complex connections between a multitude of factors. This model or framework provides a way of both explaining violence against women, and highlighting potential sites of change.

Figure One:
A Conceptual Framework for Understanding Violence Against Women



3.4 ABUSE AND VIOLENCE AGAINST WOMEN

Violence against women is a fact of life in Canadian and other societies. Some of the literature on violence against women has been reviewed previously in Chapter Two. Here, I specifically explore the definitions of abuse as well as who does the abusing. This chapter sets the stage for analysis by providing information on the factors related to the conceptual framework.

3.4.1 DEFINING ABUSE AND PATTERNS OF ABUSE

Baladerian (1991, p. 325) has defined abuse as "non-accidental injury of a person by another or the committing of acts that could result in injury, through acts of commission or omission." This type of definition emphasizes an "individual" notion of abuse. Typically, abuse is seen as something done by one person to another. There is usually also some notion of intent in definitions of abuse. Often, an act is defined as abusive only if the person deliberately intends to hurt another.

This type of definition of abuse omits a number of circumstances which could potentially be viewed as abuse. For example, if groups (rather than individuals) are involved, either as perpetrators or as victims, it may be defined as something other than abuse. The same holds true at the level of policy or systems. There are many unfair and unjust policies, such as those found in the social welfare system, which serve to demean and harm groups of devalued individuals, yet these acts would not be defined as abuse, even if the outcomes were abusive. The factor of intent also would allow abusive acts to occur on the grounds that a person "did not

know any better."

The terms "abuse" and "violence" are often used interchangeably in the literature. Some authors distinguish between acts that are legally defined as "violence" (see for instance, Statistics Canada, 1993, p. 2, which referred to "violence" as "experiences of physical or sexual assault that are consistent with legal definitions of these offences and could be acted upon by a police officer."). This research makes no such distinction. Therefore, abuse includes acts which could be considered "violence" and others which would not be.

Abuse generally includes physical abuse or battering, verbal/emotional or psychological abuse, childhood and adult sexual abuse and assault, financial or material exploitation, and neglect (Baladerian, 1991; Peters, 1987; Canadian Panel, 1993). Physical abuse may include things like slapping, shoving, hitting, mutilation, stabbing, assault and murder. Psychological abuse refers to shouting, swearing, taunting, threatening, degrading, demeaning, inducing fear, gender harassment, and witnessing abuse. Sexual violence includes rape, incest, unwanted sexual touching, date rape, and sexual harassment. Financial abuse may include withholding, diverting, embezzling or controlling a person's funds or possessions. Another, less acknowledged, type of abuse is ritual abuse. Ritual abuse has been defined in the Canadian Panel (1993:45) report as:

> A combination of severe physical, sexual, psychological and spiritual abuse used systematically and in combination with symbols, ceremonies and/or group activities that have a religious, magical or supernatural

> connotation. Victims are terrorized into silence by repetitive abuse over time and indoctrinated into the beliefs and practices of the cult or group.

In referring to the abuse of individuals with disabilities, the category of "professional/caregiver abuse" is sometimes added. This refers to abuse committed by a professional or a caregiver, and reflects the violation of trust in a relationship necessitated by the person having a disability (i.e., reliance on these individuals is due to needs created by a disability).

Peters calls for a broad definition of abuse and violence, which goes beyond sheer physical violence such as with domestic abuse or rape.

> It [violence against women] also includes sexual harassment, the objectification and exploitation of women by the media, pornography, the over-medication of women, the lack of control by women of their own bodies, and the exclusion of women from institutions of power, wealth and status (1987:21).

This approach facilitates the inclusion of hidden or subtle influences on the experience of abuse and violence, including the violation of basic human rights, as well as the impact of less "extreme" forms of abuse, which could include sexual harassment or emotional abuse. Violence and abuse can be conceptualized on a continuum from verbal/emotional abuse to physical/sexual abuse or even torture and death. The psychological and other effects cannot be minimized in any of its forms.

The research on which this thesis is based relied on a

similarly broad and inclusive definition of abuse, involving instances of individual abuse and systemic abuse. Additionally, abuse was defined during the first phase of involvement, the survey, in concrete and specific terms so that consumers (women with disabilities) would be operating according to the same basic definitions of abuse. These definitions of abuse are included in Appendix A. However, women in the interviews were allowed to utilize their own definitions of what they considered to be abuse. The women talked about self-identified abuse as opposed to legal definitions of abuse. As mentioned earlier, legal definitions of abuse are much narrower and more specific than other types of definitions, such as self-identified definitions.

3.4.2 WHO ARE THE ABUSERS?

The Canadian Panel (1993) clearly stated that, in most cases, the victims and perpetrators are not only known to each other, but share some sort of relationship. Perpetrators are most likely to be fathers, brothers, intimate partners, dates, employers, and acquaintances (Thorne-Finch, 1992; Canadian Panel, 1993; Martin, 1981). This presents a far different picture than the (false) perception of perpetrators as strangers.

Women are far more often and seriously abused by men (Walker, 1990). Also, men are far more likely to initiate the violence and to use their physical strength over women (Freedman, 1985). Because women appear to be the main victims of assault in domestic settings, many of the terms used reflect this reality. For example, terms used include wife battering, wife assault, wife

abuse, wife beating, woman abuse, and wife battery (DeKeseredy and Hinch, 1991).

Although wife abuse can and does occur in all sectors of our society, there are some patterns pointed out by DeKeseredy and Hinch (1991). They note that little is known about the perpetrators, as most studies focus on the victims. Men who were more likely to abuse included: those from low income groups, those who did not complete high school, those who are younger, and those who were unemployed (DeKeseredy and Hinch, 1991). They do note that these patterns should be approached with caution, as they are not definitive of abusers.

Pagelow (1984) also lists some of the most commonly noted features of men who abuse their wives. They tend to be low in self-esteem, have traditional beliefs about the family, are emotionally inexpressive, lack assertiveness, are socially isolated, have employment problems, are alcohol dependent, come from a violent family of origin, have authoritarian personalities, are moody, and tend to demonstrate their anger by hitting out. Additionally, Steinmetz and Straus (1974) found that people who are prone to violence have a willingness and ability to use physical violence as a resource, which they use to compensate for the lack of other resources, such as money, knowledge, and respect.

However, as noted by Fleming (1979:287), "As in the case with stereotypes, the stereotype of the abusive man just doesn't fit ... He could be anyone." This underscores the importance of not ruling someone in or out as an abuser simply because of the degree to

which he fits a stereotype.

Finally, although women may be abused by strangers, acquaintances, and intimates, by far the most common are by intimates (Canadian Panel, 1993). For example, 81% of the women who were sexually assaulted, as reported in a recent Toronto study, were victimized by men they knew (Canadian Panel, 1993). Gelles and Straus (1988:18) report that "You are more likely to be physically assaulted, beaten, and killed in your own home at the hands of a loved one than anyplace else, or by anyone else in our society."

3.5 PREDISPOSING FACTORS

There have been a number of studies outlining profiles of the characteristics associated with batterers and their victims, such as age, marital status, social status, and race and ethnicity (MacLeod, 1980 and 1987; Gelles and Straus, 1988; Straus, Gelles and Steinmetz, 1980; Wolfner and Gelles, 1993; Steinmetz and Straus, 1974; DeKeseredy and Hinch, 1991; Lupri, 1990; Kennedy and Dutton, 1989; Dobash and Dobash, 1979). Rather than presenting these patterns or profiles, I am more interested in outlining the factors that put or keep women in a vulnerable state.

Although there may be more factors, or different ways of conceptualizing or grouping the factors, I have noted seven key factors. These are listed in Figure One, and include family of origin, (economic) dependency, the love bond, fear of loss of children and keeping the family together, isolation, fear, and lack of options.

Each will be briefly outlined.

3.5.1 FAMILY OF ORIGIN

There are several inter-related aspects regarding family of origin. These include violence, culture and religion, male dominance or patriarchal structure, and women's role in the family.

Violence in the Family of Origin

Violence in the family of origin appears to be related to present or future violence, both for batterers and victims (Straus and Hotaling, 1980; MacLeod, 1987). MacLeod (1987) noted that 61% of the battering partners in her study had been abused as children, and of the women victims, up to 48% reported having experienced abuse in their childhoods. Straus and Hotaling (1980) and Egeland (1993) refer to the transmission of abuse across generations, or to a cycle of violence. Straus, Gelles & Steinmetz (1980) also found that men and women who grew up in violent homes were much more likely to commit abuse. Widom (1989) put forth the idea that violence breeds violence.

For victims, violence in the family of origin may have a number of effects. First, violence and abuse may be normalized and therefore not recognized as out-of-the-ordinary or wrong (MacLeod, 1980 & 1987; Egeland & Erickson, 1991; MacKinnon, 1991). Second, women may believe that there is nothing they can do to prevent the violence or escape the abuse. This can be seen as learned helplessness (Walker, 1979; Bowker, 1993; MacKinnon, 1991). Finally, violence in the family of origin may legitimize male domination and the perceived right to use violence to maintain male

power (Straus, Gelles & Steinmetz, 1980). Gelles and Straus (1988) believed that women, through their experiences, may have become more tolerant of domestic violence or have developed less hope of really escaping.

Culture and Religion

Another aspect related to the family of origin is the role of culture and religion. This refers to the range of behaviours which are culturally acceptable within families, and particularly between husbands and wives. Beliefs relating to culture and religion may help determine the degree of authoritarian behaviour, acceptable use of force, appropriate family roles and behaviour, and so on (Straus, Gelles and Steinmetz, 1980; Gelles, 1979). Different cultures and religions also have proscriptions around the sanctity of marriage vows, etc. Bowker (1993) notes that for women who are members of some traditional religions, staying in a violent marriage is the only way to avoid being defined as "sinful."

Our culture, although heterogeneous, is also prone to accept and approve the use of violent behaviour (Pagelow, 1984). For example, boys in particular, are taught to use force to settle differences.

In the Canadian context, little work has focused on ethnicity and religion, and only minor variations were found (Smith, 1990). This aspect still needs additional work, but we can say that there are different teachings and expectations regarding families and violence held by those of different cultures and religions.

Male Domination/Patriarchy

The degree to which the family of origin is male-dominated or patriarchal may also have an effect on family violence. Ursel (1986) refers to this as the degree of "familial patriarchy." She refers to this as a decentralized system in which individual women are subordinated to a male head of household, who has ultimate control over the lives and well-being of other family members. Although she argues that familial patriarchy has been replaced by centralized social patriarchy, wherein the subordination of women is achieved through political and economic institutions, there may still be some vestiges of familial patriarchy in operation. The family is still often viewed as a private place under control of the male head. Often, such families will also have a concomitant set of attitudes which support the use of violence against those who threaten the male dominance (Thorne-Finch, 1992; Dobash and Dobash, 1979). Adrienne Rich (1977:57) discusses the power given to fathers and husbands as follows:

> Patriarchy is the power of the fathers: a familial--social, ideological, political system in which men--by force, direct pressure or through ritual, tradition, laws, and language, customs, etiquette, education, and the division of labour, determine what part women shall or shall not play, and in which the female is everywhere subsumed under the male. It does not necessarily imply that no woman has power, or that all women in a given culture may not have certain powers.

MacLeod (1980) also refers to the social acceptance of a man's authority over his wife and children, which allows for the

acceptance of violence as normal and legitimate under certain conditions. Bowker (1988) says that men use violence to maintain male dominance in the family.

Related to this aspect is the role of women in the family of origin. Dobash and Dobash (1979) discuss the changes that occur in many families after marriage, which assign very specific roles to each of the partners. These roles may be very traditional. The male role is primarily seen as financial support. Women who were abused or subject to violence tend to have a more traditionally defined role in the home taking care of the children and her husband. In fact, women's worth can be measured along those lines (Dobash and Dobash, 1979; Gelles, 1985). A good wife's responsibilities are seen to revolve around the needs of her family. When the duties are not satisfactorily carried out, some patriarchal men feel they are justified in their violence (Dobash and Dobash, 1979; MacLeod, 1987; Thorne-Finch, 1992).

3.5.2 (ECONOMIC) DEPENDENCY

MacLeod (1980) refers to the importance of the relationship between wife battering and the economic dependence of women on men. She and others have written of the variety of abuse which women will tolerate because they have no money of their own for themselves or their children (Gelles and Straus, 1988; Dobash and Dobash, 1979; Canadian Panel, 1993; MacLeod, 1987). Gelles and Straus (1988) note that women who stay in abusive relationships do not tend to be working outside the home, have fewer resources, and limited educational resources and occupational skills.

The Canadian Panel (1993, p. 15) documented the extent of economic inequalities faced by Canadian women in relation to men. Even in the 1990's, the income gap remains wide. In 1991, the average annual wage of women working full-time was $26,842, while for men it was $38,567 (Canadian Panel, 1993). It was also noted that fewer women than men held full time positions, and women on the whole were in much poorer financial positions. Many women have very real economic dependency on their husbands and fear for what might happen to themselves and their children if they were to leave. MacLeod (1987) said that from 68 to 95% of those in shelters felt they would be living under the poverty line if they left their husbands.

The Dobashes (1979) also point out how economic dependency and patriarchal dominance result in a feeling of powerlessness for many women. Women may feel trapped in the situation. MacLeod refers to this as the hopelessness and imprisonment of poverty, which creates a psychology of defeat.

DeKeseredy and Hinch (1991) cite a number of authors regarding the importance of larger social change in order to address this reality. In the literature reviewed, economic dependence was perhaps the most common reason for women staying in an abusive relationship or otherwise "tolerating" abuse and violence.

Economic dependence may not be the only type of dependence, although it certainly appears to be at the root of others. For example, Kalmuss and Straus (1982) referred to marital dependency, which encompassed dependency on their husbands for not only

financial support, but also for status and self-esteem. Many women have been taught, beginning in early socialization, to believe that their value comes from their husbands. Although this is slowly changing, it is still pervasive in the minds of many women and men. Women may feel that an abusive marriage is better than no marriage at all (Martin, 1981; MacLeod, 1987). In addition, Pagelow (1984) states that the lack of ability to function independently because of health, education or occupational deficits increases the probability of violence in an intimate relationship.

3.5.3 THE LOVE BOND

The emotional bonds that victims often feel for their abusers have been documented by a number of writers (MacKinnon, 1991; MacLeod, 1987; Thorne-Finch, 1992; Martin, 1981). Despite the abuse, many women report that they still love their husbands (MacLeod, 1980,1987). Gelles and Straus (1988) and others (Martin,1981; MacLeod,1987; Dobash and Dobash, 1979) report the strength of this love bond, as well as the recurring belief of women that their husbands will change. Many husbands promise to change (Martin, 1981; MacLeod, 1987) MacLeod (1987) notes that often women explain away the abuse as acts of love or jealousy. Later, they go to great ends to attempt to stay in love, or what is their ideological vision of their partner and love. Pagelow (1984) also reported hope for change and love of the person as factors in staying. In fact, MacLeod (1987) found that among women who report violence, most do so out of hope that her partner will get help and they will again be "in love with each other."

Many women and children who have been victimized repeatedly not only believe the situation will change, but also attempt to protect their abusers from outside intervention (Finkelhor, 1983). Finkelhor notes that many women go back to their husbands out of a concern for the husband's welfare and well-being. Finkelhor also noted this same pattern among children who, although they wanted the abuse to stop, had strong emotional ties to their parents.

3.5.4 FEAR OF LOSS OF CHILDREN / KEEPING THE FAMILY TOGETHER

This factor refers to the fear of loss of children, and the desire to keep the family together. Many women rightly fear the loss of their children (MacLeod, 1987; Dobash and Dobash, 1979). Due to the psychological effects of battering, many women, in fact, begin to appear mentally unstable and, therefore, unfit as parents (MacLeod, 1980). Thorne-Finch (1992) notes that many men are usually able to present good images to the public. In economic terms, men are viewed as the best choice for custody. Also, due to low self-esteem and threats made by the abuser, many women truly believe that they will lose their children if they leave (Martin, 1981; MacLeod, 1987).

The responsibility or wish to keep the family together, is also a very strong reason for women to remain in or return to abusive relationships. Dobash and Dobash (1979) note that women are socialized from an early age to believe that it is their responsibility to keep the family together. Related to this is the belief that they must stay for the sake of the children -- to avoid the stigma of

coming from a "broken home." Gelles and Straus (1988) and MacLeod (1987) note that women blame themselves for family break-ups, and may feel ashamed if a marriage does not work. Pagelow (1984) reported that women often feel guilt and have feelings of failure due to family disruption. Staying with the abuser is also seen as better than raising children alone. As well, staying in an abusive relationship can mean that others will not know what is happening (Martin, 1981). Martin (1981) also reiterated that it is seen as the woman's responsibility to have a good marriage and that women's worth is judged in relation to marriage.

3.5.5 ISOLATION

Isolation is cited consistently as a factor underlying women's vulnerability (Canadian Panel, 1993; MacLeod, 1980, 1987; Gelles and Straus, 1988; Martin, 1981; Pagelow, 1984; MacKinnon, 1991; Steinmetz et al., 1983; Gelles, 1985). As noted by the Canadian Panel (1993) and Chalmers and Smith (1988), isolation may be physical, social, or psychological. Women may be isolated by geography, such as is experienced by women in rural areas, or they may be isolated in more subtle ways (MacLeod, 1987). MacLeod (1987:28) also refers to the double isolation of those in rural or isolated areas, aboriginal women, immigrant women, teenaged women, disabled women, and women on military bases. These women lack access to help and services. Yllo (1993:55) gives examples of how men achieve power and control by using isolation: "Controlling what she does, who she sees and talks to, what she reads, where she goes; limiting her outside involvement; using

jealousy to justify actions." In other words, men may actively use tactics to create isolation. They may do this by preventing their wives from working outside the home, by controlling contacts with friends and family, or by monitoring their wives' activities.

The family itself is a socially isolated, private institution, that is somewhat insulated from outside scrutiny (Pagelow, 1984; Gelles and Straus, 1988; Canadian Panel, 1993; MacLeod, 1987). Gelles (1979:14) notes that "Where privacy is high, the degree of social control will be low."

Women may also feel that they are alone. They may believe, often correctly, that friends and family will not believe or help them (MacLeod, 1980). "Violence isolates any of its victims, in psychological terms" (Chalmers and Smith, 1988, p. 221). MacLeod (1980) notes that isolation serves to trap women in a vicious cycle of violence. Other factors which may contribute to isolation include economic dependency, child rearing, and lack of work outside the home (Dobash and Dobash, 1979; MacLeod, 1980).

3.5.6 FEAR

Another factor which plays a role in women's experience of violence is fear. This factor has been noted by MacLeod (1980, 1987), Dobash and Dobash (1979), Martin (1981), Pagelow (1984), Gelles and Straus (1988), and MacKinnon (1991). Women may give a number of different reasons or rationalizations for staying, but fear is the common element (Martin, 1981). She may fear being hurt further or she may fear reprisals if she tells. He may threaten her if she tries to leave (MacLeod, 1987).

She may also fear endangering others. MacLeod (1980), Pagelow (1984) and Martin (1981) all reported that the women feared for the safety of family and friends. This may have been a response to direct threats, or an unspoken fear of violence happening to them. This fear may also extend to the children. If she leaves without them, she may feel he will hurt them; or if she takes them, she may fear him tracking them down or stalking her (Martin, 1981).

Finally, many women fear for the safety of the abusers. NiCarthy (1983: p.17) notes that many women believe the men will "fall apart or commit suicide". As a result of guilt, or love for the abuser, they may worry about his safety at the expense of their own safety.

3.5.7 LACK OF OPTIONS

This element is related to a number of the others. Women who are being victimized may feel they have nowhere to go, or that they lack any options. MacLeod (1987) notes that an increasing incidence of wife abuse has resulted in many full shelters. Without jobs, particularly when there are children to support, there may, in fact, be nowhere women can afford to go (Dobash and Dobash, 1979; MacLeod, 1980; Gelles and Straus, 1988). In addition to emergency shelters, there is the need for access to safe, long-term housing (DeKeseredy and Hinch, 1991). If women cannot find jobs or afford housing, many return to their husbands out of sheer desperation (MacLeod, 1980).

Feeling that she has no options may leave the woman feeling helpless (Pagelow, 1984). She may become immobilized and feel

there is nowhere she can go and nothing she can do. Additionally, the decision to leave may include a fear of leaving the community, having children change schools, and being cut off from family and friends (MacLeod, 1987). This uncertain future may seem equally bleak to staying in the situation.

Each of these factors -- singly and in combination -- provides a context for violence against women. They essentially are the risk factors that predispose women to the experience of abuse or violence. As shown here, there is a formidable body of literature documenting the ways in which this constellation of factors explains the behaviours of both perpetrators and victims of violence. These factors span the range of the psychological through to the social structural, and remind us of the multifaceted nature of the problem of violence against women in contemporary society.

3.6 IMPACTS OF ABUSE ON WOMEN

Violence and abuse may have deep and far-reaching effects on women. "While bruises may fade, other effects--for example, a shattered self-esteem--can be of extended duration, or even permanent" (Thorne-Finch, 1992, p. 45). There may be a number of variable impacts on the victims, which affect different women to different degrees. What follows is a compilation of some of the major documented effects of male violence on women. These have been categorized as psychological and physical health problems, the denial of abuse, and an inability to identify and pursue non-abusive

relationships.

3.6.1 PHYSICAL AND PSYCHOLOGICAL HEALTH PROBLEMS

There are a number of physical and psychological health problems experienced by victims of abuse. There is no "normal" or typical reaction, but a variety of different reactions. Thorne-Finch (1992:31) notes that the effects may be mediated by factors such as "the woman's previous value system, her history of abuse, the nature of the violence, whether the assailant was known to the victim, the woman's age, how soon she sought help after the violence, and how effective that help was."

Physical Problems

The physical effects are usually the most immediate, and often, the most visible. Due to their relative visibility, they may be viewed as objective markers that something is happening, and may be more difficult to explain away (Dobash and Dobash, 1979; MacLeod, 1987). This can include direct physical trauma, such as bruises, broken bones, burns, cuts, lacerations, etc. The physical effects can also include mutilation, long-term disability and death (Gelles and Straus, 1988; Ridington, 1989b; Stimpson and Best, 1991).

Other physical responses may include secondary problems such as clinical depression, increased substance abuse, eating disorders, internal disturbances, unwanted or traumatized pregnancies, sexually transmitted diseases, and generalized tension and sleep disorders (Thorne-Finch, 1992; Gelles and Straus, 1988; Dobash and Dobash, 1979).

Depression is a common response, perhaps a combination of helplessness, anger, sadness and futility. Often women are treated with tranquilizers rather than counselling to get at the root cause of the depression (Dobash and Dobash, 1979).

Substance abuse, in terms of the over-use of drugs and/or alcohol, may be used as a way to numb the pain of their experiences. This may be an attempt to live with a problem women are unable to escape (Turner and Colao, 1985).

Many victims report at least short term changes in eating habits. Often, it is disrupted only for the time of and immediately following the violence (Burgess and Holmstrom, 1974), and returns to normal shortly thereafter. However, for others, being able to regulate caloric intake may be one of the few areas of perceived control for a woman. Hence, a number may develop full-blown eating disorders, such as anorexia and bulimia (Thorne-Finch, 1992).

Internal physical disturbances often follow battering and sexual assault. This may include nausea and vomiting, either in reaction to recalling the violence or in anticipation of pending violence (Burgess and Holmstrom, 1974). Additionally, women who have been sexually violated often experience vaginal and urinary problems (Burgess and Holmstrom, 1974).

Another related medical problem, particularly in the case of sexual assaults, is pregnancy. This may be accompanied by an often difficult decision regarding whether or not to continue the pregnancy. Burgess and Holmstrom (1974) note that many women, who lack safe abortion facilities or do not wish to tell others about

the sexual assault, give birth to children, despite the emotional scars left behind of the rape.

There is also the issue of violence during pregnancy. Eli et al. (1992) note that the assault of women during pregnancy is a significant concern, and a problem both for the health of the pregnant woman and the developing fetus. Problems include: low birth weight, fetal fractures and fetal abnormalities, early labour, or damage to the mother's spleen, uterus or liver. Other more indirect risks that they note are elevated stress, lack of access to prenatal care (due to isolation), increased use of other risk factors as coping mechanisms (due to stress of victimization, such as smoking, drug and alcohol use), and inadequate maternal nutrition.

Sexually transmitted diseases are another concern, particularly with regard to sexual assaults (Thorne-Finch, 1992). Although most can be adequately dealt with, some, such as AIDS, cannot, and the result may be the emotional strain of dealing with a terminal illness, and ultimately, with death.

Finally, in terms of physical concerns, women who have been abused may suffer headaches, fatigue, and overall tension (Thorne-Finch, 1992). Poor sleep, nightmares, and sleep disorders may also occur (Gelles and Straus, 1988).

Regardless of the actual form of the effects of the trauma, it is apparent that the physical impacts may be great. Thorne-Finch (1992) notes that the physical trauma may also leave more permanent physical and emotional scars.

Loss of Self-Esteem

This is one of the most commonly reported impacts on women who have experienced violence and abuse (MacLeod, 1987; Dobash and Dobash, 1979; Thorne-Finch, 1992; Pagelow, 1984; Gelles and Straus, 1988; Canadian Panel, 1993). Most authors agree that victims of all types of violence share the experience of denigration that results in lowered self-esteem. Gelles and Straus (1988) note that battering leaves women feeling worthless, powerless, helpless, and humiliated. Additionally, they found that shame and self-blame were the two most common feelings expressed by battered wives. MacLeod (1987) also found this. The shame may serve to keep them silent, and the self-blame has them believe they deserved the abuse (perhaps even believing that they provoked the abuse). This further lowers how they feel about themselves.

Additionally, frequent psychological abuse and ridicule, not only is degrading, but makes many women believe that they are in fact worthless. When frequently told that she is worthless, stupid, ugly, etc., a woman begins to believe this. Taken to its extreme, this lack of self-confidence may result in women turning the violence on themselves in attempts at suicide (Gelles and Straus, 1988; Kelly, 1988; MacLeod, 1987).

Helplessness and Hopelessness

Another common impact is a feeling of shame and humiliation (Pagelow, 1984; Gelles and Straus, 1988). The woman feels that the abuse is her fault. Self-blame is common to most victims of family violence. According to Finkelhor, this is more pronounced in family

violence than in other types of crimes or violence. "Although victims of violence and exploitation in other settings also blame themselves, it is particularly severe for victims in families, where the abuser is a powerful person who has a powerful effect on shaping victim's perceptions" (Finkelhor, 1986:8).

Walker (1979) notes that victims of family violence are far more likely to feel helpless and trapped. This is more likely than in crimes involving strangers. Walker explains it as being due to living with the abuser, fearing retribution if they tell, as well as being dependent upon them. Walker also refers to the learned helplessness experienced by battered wives, wherein they seem unable to do anything to stop the abuse or escape from it. Eventually, they feel helpless, hopeless, and paralyzed.

Other Psychological Effects

Other common effects include women feeling like they deserve the abuse (Gelles and Straus, 1988). Often, this is connected to previously low self-esteem, but it may also be because the abusers have told them that it is their fault.

Further isolation is another important impact, which serves to increasingly silence women and keep them from accessing help. The abuse may in fact make the victim even more emotionally dependent on the batterer (MacLeod, 1987).

Many women also feel incredible anger, bordering on rage. However, Thorne-Finch (1992) notes that since it is not socially acceptable for women to display this level of anger, particularly toward men, many women internalize the anger, leading some to

distance themselves from their feelings in order to cope. Women are rarely encouraged to let the anger out, as a normal and healthy response to being victimized.

Fear and anxiety are also common effects (MacLeod, 1987; Thorne-Finch, 1992; Gelles and Straus, 1988). Survivors of abuse and violence are more likely to see the world as an unsafe place (Gelles and Straus, 1988). When the violence occurs in the home, the world may seem to hold no safe places.

Finally, the last effect relates to damaged or destroyed trust (Thorne-Finch, 1992). Thorne-Finch (1992:39) notes "Trust should be a sacred entity. Once it has been damaged it is particularly difficult to repair." The fact of the matter is that we try and teach children to trust certain people in their lives, and yet for some, those same people are those most likely to abuse them. When that happens, the violation and harm may be irreparable. Once that trust is broken, this generalizes, and it becomes more difficult to trust anyone in the future.

3.6.2 DENIAL OF ABUSE

A common response to abuse experienced by women is a denial of the abuse (MacLeod, 1987; Straus, 1972; Kelly, 1988). Straus (1973) believes that most family violence is either denied or ignored. It is often only when the abuse becomes unbearable, very frequent, or can no longer be covered up, that women cannot deny what is happening. MacLeod (1987:42) notes that "Women who are battered do not generally define themselves as battered women the first time they are battered." In fact, MacLeod reports a real

ambivalence on the part of the battered woman.

Often the abuse and battering are defined as other things (MacLeod, 1987; Gelles and Straus, 1988; Kelly, 1988). This includes jealousy, a sign of caring, wanting to be together, possessiveness, etc. Almost any explanation is better than one of battering.

Kelly (1988) asked specifically about how women defined the events. She noted that more than 60% of the women in her study did not define their experiences as a form of sexual violence. She did find that approximately 70% of the women changed their definitions of the experiences as time went on--relabeling the incidents as abusive.

Naming is an important first step in being able to do something about abuse (Kelly, 1988; MacLeod, 1987; Canadian Panel, 1993). Many women are unsure about how to define or label certain events, and this keeps them from acting on it. In order to do something about abuse or violence, such as seek outside services, women must define the incident(s) as being beyond normal, acceptable or inevitable behaviour, and as abusive (Kelly, 1988). Further, naming must occur before one will contact particular services or report it to the police.

Some women are unable or unwilling to apply the names to their own experience, often because they were afraid of what it would mean. It is hard to accept that someone you love is beating you (MacLeod, 1987; Canadian Panel, 1993). In those cases, it might be easier or more acceptable to find reasons to explain it away.

Kelly (1988) discusses forgetting and minimizing as two

important coping strategies. In forgetting, many of the women simply forgot about the abusive experiences over time. She says that we "forget experiences in order to cope with an event that we do not understand, cannot name, or that places acute stress on our emotional resources" (1988, p. 124). Forgetting is most likely to occur when we have no names for an event or framework for dealing with it. Memory may only occur when there is a way of making sense of the event or reactions. Some may also forget in order to avoid being viewed as a "victim" (Kelly, 1988). Kelly (1988) found that remembering almost always involved a trigger of some sort, such as reading, talking with someone, or being revictimized.

Minimizing refers to the "process whereby women tried to limit the importance and impact of incidents that they defined as abusive to some degree" (Kelly, 1988:126). This was also a commonly used coping strategy. Examples include making flippant remarks or saying "it was nothing really." Although sometimes done as a coping strategy, minimizing, she says, may also be due to stereotypical or limited definitions; in these cases, a woman's experiences may be "as bad" as the stereotypes (e.g., the stereotype of violent rape). If an event is minimized, it is not only seen as more manageable, it is also treated as not requiring action. Kelly notes that minimizing denies the impact of an assault. In intimate relationships, Kelly discovered that minimizing was more likely to occur when there were less serious (physical) reminders and when there were gaps between incidents.

Another surprising but common effect upon victims of abuse

and violence, particularly with regard to family violence, is loyalty to the abuser (Pagelow, 1984; Finkelhor, 1986; Gelles and Straus, 1988). In fact, victims may go to great lengths to protect their abusers from outside detection and intervention. Explanations for this include love, fear, shame, guilt, etc. Whatever the reasons, the allegiance is often quite strong (Finkelhor, 1986).

3.6.3 INABILITY TO IDENTIFY AND PURSUE NON-ABUSIVE RELATIONSHIPS

The impact here includes two related occurrences. One is the inability to identify and pursue non-abusive relationships. The second is the idea that a long-term effect of sexual violence, particularly incest, is a future vulnerability to sexual violence.

Schechter (1982:20) notes that "Most people feel ambivalent when ending a long term relationship. Major change is always difficult, often slowly and haltingly undertaken." Major change is difficult at the best of times. When one adds the low self-esteem, guilt, and emotional dependency felt by many victims (MacLeod, 1987), the possibility of change is even worse. Walker (1979) believes that those suffering from battered woman syndrome have decreased self-confidence, increased passivity, and are in a state of learned helplessness. These conditions serve to keep women in the same or similar situations.

A number of authors have reported on this cycle of violence, whereby women or children living in violent homes were more likely to be future victims of violence (Pagelow, 1984; Gelles and Straus, 1988; Gelles, 1974). Dobash and Dobash (1979) also note that

women may learn to be "better" victims by normalizing a certain degree of abuse and violence.

A pattern was noted where women victims tend to be attracted to the same sort of man or situation (MacLeod, 1987; Canadian Panel, 1993; Gelles and Straus, 1988). Perhaps because they lack healthy role models against which to compare, or have become immune to the violence and abuse, many women are unable to identify, or pursue, healthy, non-abusive relationships. They may escape one only to end up in another.

Russell (1984) discovered that sexual abuse, especially incest, makes women vulnerable to further sexual violence. She believes that early experiences may help socialize women into the role of "victim." Additionally, Finkelhor (1983) suggests that abusive men may pick up on the vulnerability of some women, and thus place the women in further jeopardy.

Whatever the reasons may be, what is emerging from the literature is that some women may experience this inability to pursue healthy and non-abusive relationships. Or, they may be so distrusting as to pursue no relationship at all (Kelly, 1988). This suggests the need for women to receive adequate counselling to try and avoid future pitfalls.

It is worth noting that each of the impacts identified has a bearing on the women who experience violence. The effects of violence may contribute to all of those factors that have been found to predispose women to violence, and have a bearing on women's

definitions of abuse and abusers. The intricate web suggested here points to the need for interventions to stop the cycle of violence that numerous studies have suggested is all too pervasive.

3.7 INTERVENTIONS

Interventions are intended to slow or stop the cycle of abuse and violence. Interventions may be direct or indirect. Indirect interventions can be made which aim to address "causes," such as social programs for poverty and education; direct interventions can also be aimed at "consequences," such as those which try to build victims' self-esteem or increase women's knowledge about abuse. Indirect interventions are supposed to intervene between cause and consequence. Examples of direct interventions to violence and abuse include the law and social services such as shelters.

In this section, I will briefly outline the formal and informal sources of intervention and support which might be available to women. The formal portion consists of social services, the medical and mental health system, and the legal system. The informal consists of social supports provided by kin and others.

3.7.1 SOCIAL SERVICES

Social services include a conglomeration of services delivered in the community. These services are usually viewed as "women's" services (Canadian Panel, 1993). Social services include crisis counselling, intermediate and long-term individual and group counselling, emergency shelters, and second stage (medium term) housing programs. In Manitoba, the Women's Advocacy Program, has

been designed to support victims and provide a bridge between social services and the criminal justice system (Ursel, 1991). Groups for batterers, such as EVOLVE in Manitoba (Ursel, 1991) may also be included in the social services system. These various social services are provided by a combination of government funded services, non-profit community groups, and private practitioners. Social services may be supported by provincial or municipal social assistance or welfare programs.

The various social service elements tend to suffer from a number of issues which limit their effectiveness. The most general difficulty or criticism is that they respond only individually and "after the fact," which does less to reduce the numbers of women being affected by abuse and violence (Pagelow, 1984; Gelles and Straus, 1988; Davis and Hagen, 1992).

Another serious concern is the overall lack or availability of services. For example, although the number of women's shelters has dramatically increased over the last decade [71 in 1979 to 230 in 1987, to 402 in 1993], they became full shortly after creation (MacLeod, 1980 and 1987; Canadian Panel, 1993). Counselling programs are in short supply and have lengthy waiting lists; those available in private practice are often not accessible to most women due to the costs of such services (MacLeod, 1987; Canadian Panel, 1993; Thorne-Finch, 1992). There is also a lack of options for women leaving shelters and second stage housing, particularly for those with limited financial resources (Canadian Panel, 1993). DeKeseredy and Hinch (1991) note the need for increased financial

and housing assistance.

MacLeod (1987) also notes that many of the services which are available are primarily for women who have been battered; others may be unable to find or access services. Another difficulty, although one which is being addressed, is in the lack of follow-up and support services (MacLeod, 1980; Canadian Panel, 1993).

Related to the lack of services is the lack of long-term, stabilized and sufficient funding to services (Canadian Panel, 1993; MacLeod, 1987). Many services are forced to spend a great deal of time and energy searching for funding, and services operate on a short-term basis. MacLeod (1980) has said that funding is related to a lack of official recognition and support for wife abuse services.

Services also lack a coordinated framework (Canadian Panel, 1993; MacLeod, 1987). Kelly (1993) notes that to receive help, one must label her specific abuse, as many services are delivered on the basis of types of abuse and violence, rather than being generically available. A more coordinated, comprehensive and cohesive approach has been called for by women who participated in the Canadian Panel consultations. Otherwise, services tend to operate in isolation and competition, and may not offer a full range of options to women in need.

Finally, aside from services delivered from a feminist perspective, social service workers and agencies have been accused of having patronizing and paternalistic attitudes (MacLeod, 1987; Gelles and Straus, 1988; Dobash and Dobash, 1979; Canadian Panel, 1993). This may result in women being seen as partially to blame

for their experiences and being given inappropriate advice and limited responses.

Social services are intended to deal with the impacts of abuse and violence as well as to mitigate their experiences by providing immediate shelter and support. However, if social services are not effective, there may in fact be further risk for the women who may be at risk of being further victimized. This may be as a backlash for having sought assistance or in rendering women more reluctant to seek help in the future (Canadian Panel, 1993; Gelles & Straus, 1988). Social services are often provided as part of a larger response. This response can include the medical and mental health systems, as well as the legal system.

3.7.2 MEDICAL AND MENTAL HEALTH SERVICE SYSTEMS

The medical and mental health systems are important components of interventions to respond to violence against women. For example, the hospital and the family doctor are two frequently used primary resources in cases of sexual assault victimization. For others, contact may come years after victimization. Whatever the case, most survivors of violence do eventually come in contact with the medical or mental health systems at some point (Canadian Panel, 1993). The medical and mental health systems include health care professionals in hospitals and clinics, such as doctors, psychiatrists and nurses, as well as the system of government-run mental health services, such as community mental health programs and workers.

Like the social services system, there are issues with the medical and mental health systems that limit their utility and

effectiveness. Perhaps the most encompassing issue is the approach and philosophy of traditional health care services. The health care system tends to be patriarchal and male dominated (Dobash and Dobash, 1979; Canadian Panel, 1993). It reflects the unequal power relations between women and men held in society at large (Canadian Panel, 1993). In an authoritarian and hierarchical structure, patients hold the least power (Canadian Panel, 1993; Dobash and Dobash, 1979). Women in the system have even less power.

Another problem is that the health care system, relying on a biomedical model of medicine, is unable to deal with the larger problem of violence against women. Medicine can only intervene at the individual, symptomatic level. Stark et al. (1979) argue that due to patriarchal medical ideologies and practices, health care professionals do not always recognize battering and other types of abuse, and may instead falsely label women as having individual psychological problems. In fact, Rosewater (1988) reports that often the "paranoia" and "confusion" created by the repeated experience of violence or emotional trauma is misdiagnosed as psychiatric symptoms, such as schizophrenia or borderline personality disorder. Victim responses are "pathologized," perhaps inappropriately, and in many cases treated with tranquilizers and antidepressants, which serves only to mask the problem (Dobash and Dobash, 1979). Doctors are unable or unwilling to deal with the social causes of the problem, and through their individual focus may actually divert attention away from the real causes of violence (Dobash and Dobash, 1979).

Even with increasing numbers of women seeking help from medical and mental health practitioners, these health care workers may have limited knowledge of abuse and violence (Dobash and Dobash, 1979; Canadian Panel, 1993). They may not recognize the signs of abuse or be aware of the best responses or resources to offer. Frequently, they are unaware of local services which might be better sources of assistance and support (Canadian Panel, 1993). Benjamin and Adler (1980) as well as Kurz and Stark (1988) also report that due to their "professionalism," most doctors and mental health professionals tend to adopt a "hands-off," "let's not get involved" attitude toward abused women. This situation is changing, with the increase in physician education on the subject, such as offered in the Journal of the American Medical Association (JAMA) article written by the Council on Scientific Affairs of the American Medical Association (1992).

Medical and mental health practitioners also tend to individualize problems. In many cases, these problems require social change, such as an elimination of patriarchy, or equal work opportunities, rather than psychological treatment, yet that is beyond their scope (Canadian Panel, 1993). Unfortunately, this may lead women to believe that the problem is how they cope with things, etc. Doctors cannot write prescriptions to deal with poverty, patriarchy, isolation and oppression.

Since these services deal only with the victims, victims are sometimes given the message that they are to blame. This further deepens the trauma they are already experiencing (Dobash and

Dobash, 1979).

Finally, the health care system tends to have a paternalistic view of women (Dobash and Dobash, 1979). Doctors and mental health workers may be directive and make decisions for women, further perpetuating dependence and loss of control. What is needed are more empowering and strengthening resources.

3.7.3 THE LEGAL SYSTEM

Over the last decade, changes have been made to the enforcement of the law which increasingly state that violence against women will not be socially tolerated (MacLeod, 1987; Canadian Panel, 1993). Whether or not this has been effective is another matter. MacLeod (1989:23) lists the three main goals of the justice system in relation to wife battering as being: to protect battered women and their children; to deter men from battering their wives; and, to serve a symbolic and educative role denouncing wife abuse. MacLeod believes that there has been a great deal of success with the third goal of symbolism and education, but much less with regard to protection and deterrence. One important development is that what happens in the family is no longer viewed as a private matter.

However, the Canadian Panel report (1993) notes that although the laws are clear, judges and others involved in the process are given a great deal of latitude in how they treat individual cases. Sentencing patterns, custody decisions, and individual commentary by judges reveal continuing patriarchy and paternalism in the system, as well as a lack of understanding of the atrocity of

violence and abuse (Canadian Panel, 1993). Ursel (1994) described one attempt to overcome these difficulties--the Winnipeg Family Violence Court--which began in 1990. Ursel found that this specialized court was able to achieve more expeditious processing as well as more consistent and appropriate sentencing.

The Canadian Panel (1993) noted some current difficulties for women within the justice system. One is that the traditional legal framework presumes innocence of the accused. The Panel noted that this often leads to disbelief of the victim. It may also mean less protection for the woman both inside and outside of court. The Panel also reported that judges often fail to protect the victim from embarrassment and humiliation under cross-examination. Sentencing was a second area of concern. The Panel (1993:223) found that "sentencing practices reveal a high level of tolerance for crimes of violence against women." Sentences are often short and influenced by factors such as the accused's reputation in the community. The Panel report also revealed that women found the probation and parole systems to be failures with regard to protecting women. Women felt that their needs and concerns for safety from the abuser should be better addressed in the future. Women in the Panel consultation process also called for changes or new legislation in a number of key areas. This included stalking and threats of violence, high risk offenders, rape shield legislation, prostitution, pornography, and hate literature/crimes.

The second major area of the legal system to consider is the police response. Women in the Panel report were critical of the

police. "Help, when it is available, often comes from those who do not understand wife abuse and have little or no training" (Canadian Panel, 1993, p. 214). Police were seen as lacking knowledge about violence against women. They were also viewed as not taking the issue seriously. In order to overcome this problem, more and more departments are building specialized training and sensitivity programs into their police training (Canadian Panel, 1993). As well, greater inclusion of women, including those of minority backgrounds, was suggested as a positive step.

Protocols and charging policies were also found to be faulty by the Panel. Although the RCMP adopted a national wife assault charging policy in 1986, and other jurisdictions (such as Manitoba, with its zero tolerance policy) followed suit, there remains a great deal of discretion in charging. This discretion has been dramatically reduced in Winnipeg with the introduction of Winnipeg Police Department protocol changes adopted in June, 1992. The Family Violence Court was also important in dealing systematically with issues of family violence. Aside from these local initiatives, the Panel found wide discretion exercised in cases according to whether someone would be viewed as a "good" witness--i.e., "white, middle class, able, heterosexual, etc." (Canadian Panel, 1993, p. 216), whether there are visible injuries, and whether there are witnesses.

Finally, there were difficulties with police response time, and the effectiveness of restraining orders and peace bonds. Women in panel consultations reported that police time is slower for repeat calls to the same address, even though the situation might be more

dangerous to the woman. However, repeat calls seemed to create complacency on the part of law enforcement personnel. Additionally, although restraining orders and peace bonds are designed to limit men's access to women, they were repeatedly found to be ineffectual and difficult to police.

In sum, a number of changes are needed to increase the legal system's response to victims of wife abuse. Interventions play a critical role in violence and abuse. The legal system provides very important practical and symbolic functions. Unless the systems are effective, they may in fact put women in further danger. Also, an ineffectual response may give perpetrators the perception that they will be able to get away with their crimes.

3.7.4 SOCIAL SUPPORTS

Social supports are an essential determinant of whether a woman is able to escape an abusive situation or to keep from returning to one. Potential sources of social support include the social programs discussed earlier. Equally or more important is support from friends, family, neighbours and other community members.

Friends and family are often viewed as an important source of social support and assistance. Gelles and Straus (1988) found that women who have family or personal troubles are most likely to turn to relatives, friends or neighbours for help. However, in cases of wife assault, women are less likely to turn to anyone for help, due to the high degree of shame which is often involved (Dobash and Dobash, 1979; Gelles and Straus, 1988; Canadian Panel, 1993). When

they do, friends and family are often reluctant to become involved (Martin, 1977; Dobash and Dobash, 1979; Gelles and Straus, 1988; Benjamin and Adler, 1980; Canadian Panel, 1993).

MacLeod (1980) also noted that there is often a lack of support from family and friends. In many cases, they do not believe the woman, and may even side with the man. If the woman leaves, she risks losing whatever community, schools, friends, etc. she previously had. In a number of cases, many women were encouraged to go back to an abusive situation by family and friends.

In some cases, friends, family and neighbours do get involved. Dobash and Dobash (1979) found that of those who chose to be involved (usually females), many were willing to lend a sympathetic ear. However, more active involvement, such as providing shelter, confronting the abuser, protecting the woman from further harm, or actual intervention, were more rare.

Another source of social support, which is gaining in availability, is found in self-help support groups (Canadian Panel, 1987; Dobash and Dobash, 1979; Canadian Panel, 1993). Women are able to get together to provide mutual support, understanding and assistance. This is a valuable tool, with participants being able to understand the feelings and experiences of other members. This and other forms of social support are essential if women are to feel less alone and able to maintain their independence.

In sum, social supports, made up of kin and non-kin, form the informal system of interventions. These interventions may be more

important to individual women than the other formalized systems. Therefore, it is important to bolster the ability of these people to provide supports to victims.

The framework presented in this chapter represents the current research on the causes and consequences of violence against women. It includes a variety of factors and draws our attention to the social basis of violence. With this emphasis, we are reminded that while the experience and trauma of abuse is a deeply personal and private trouble, it is most effectively explained through a consideration of the social and structural factors that spawn such behaviour. Such a framework suggests as well the sites where we might reasonably seek to prevent or halt violence against women.

The framework discussed in this chapter is derived from research on violence against women, yet most of that research has failed to examine the distinctions that no doubt exist among various segments of the diverse female population. So the question that arises is whether the model used to account for violence against women in general applies to the experiences of women with disabilities. In other words, what happens when the backdrop for explaining violence against women expands to include ableism, referred to in Chapter One, along with patriarchy? Will these factors apply to women with disabilities, or are there other factors to consider? These questions are addressed in Chapter 6 and 7. However, before doing so, I will present the methodology and the women in my study.

CHAPTER FOUR: METHODOLOGY

This Chapter begins by describing the purpose of the research. Then, in order to provide a context for the research, a description of Independent Living Centres and the Independent Living philosophy is provided. As well, I discuss the design of the study, the research instruments, data collection, and data analysis. Finally, I describe my role in the overall project.

The research consists of an analysis of data collected by the Independent Living Resource Centre (ILRC) during their 1993 Abuse and Disability Project. This project was designed to explore the issue of abuse within the disabled community (male and female) in Winnipeg, Manitoba and to gain consumer insight on future roles and activities. The project was supported financially by the Secretary of State of Canada, Disabled Persons Participation Program. My participation in the project was as Project Coordinator. I was responsible for overall project direction as well as for designing and implementing tools to be used in data collection.

4.1 PURPOSE OF THE RESEARCH

The project was designed specifically for the purpose of examining the experiences of abuse among people with disabilities who were connected to the Independent Living Resource Centre (ILRC). Women with disabilities were included from the inception of the study as part of the primary respondent group. A multi-method

approach, consisting of survey, interview, peer/focus groups, and workshops, was used in the initial project in order to gain information on experiences of abuse, barriers to help-seeking, and potential roles for the ILRC and other community organizations.

I then examined a sub-section of the data in order to find out more about the experiences of women with disabilities and abuse. Since the area is under-researched, I believed that my exploratory research would begin to identify themes and patterns in those experiences.

4.2 THE CONTEXT OF MY RESEARCH

A unique aspect of the project was that it was grounded in the independent living movement philosophy. A grassroots, community collaboration approach was used in formulating and conducting the study.

The ILRC in Winnipeg is part of a national network of Independent Living Centres (ILC's). There are 17 other centres across Canada at the present time, which are connected through an umbrella organization known as the Canadian Association of Independent Living Centres (CAILC). All Canadian ILC's are mandated to promote and enable the progressive process of citizens with disabilities taking responsibility for the development and management of personal and community resources (Independent Living Resource Centre, 1985).

The ILRC is a cross-disability organization created by, for, and with individuals with disabilities. It is open to individuals of all

ages and with any type of disability. The independent living philosophy is directed by the following principles:

1) consumer control - the person with the disability is in charge of making the decisions which affect her life;

2) community based - services should be based on needs stated by the consumer community and should avoid duplication; and

3) individual risk-taking and responsibility - once given appropriate information, the individual takes charge of her own life along with accepting responsibility for those decisions, including learning by taking risks and possibly through making mistakes.

The philosophy is grounded in the belief that the daily experiences of living with a disability make consumers the best source of what is or is not in their interests. The independent living philosophy, being a self-help or self-directed model, suggests that empowering individuals to take more control over their decisions and environments will, in the long run, lead to the best decisions. This runs contrary to the rehabilitation or medical models of dealing with people with disabilities. These are based on professional or expert control.

The ILRC project included a number of other objectives and activities, such as a needs assessment survey, community networking and training, interviews, etc. These are listed in Appendix B.

4.3 DESIGN OF THE STUDY

The ILRC Abuse & Disability Project involved a survey a group of men and women with disabilities in Winnipeg. As our sample, we used people with disabilities whose names were on the ILRC consumer mailing list. As the ILRC is a cross-disability organization, we believed there would be representation from individuals with varying types of disabilities.

We chose a survey approach for a number of reasons (Backstrom and Hursh-Cesar, 1981). First, it was an expedient and cost-effective approach for gathering a large amount of information from a large number of respondents. Second, it is a systematic means of getting information. Third, it met our needs in that we wanted an overall picture of the situation rather than in-depth information. Finally, and most important for our purposes, mail-out survey questionnaires allowed respondents to be anonymous and to answer questions at their own pace. Since questions about abuse and violence were viewed as very personal and sensitive, and requiring respondents to be vulnerable, we felt the self-administered survey approach offered the highest degree of personal safety and control. In order to enhance feelings of safety, we included a list of community resources which offered counselling and crisis services.

Survey Preparation

The survey was developed and reviewed by the ILRC Abuse Advisory Committee, which was comprised of ILRC staff, consumers, family members, representatives of disability groups, organizations

serving people who have experienced abuse, and academics. As per recommendations on Research By/For/With Women With Disabilities (Wight-Felske, 1990), the research questions and data collection methods were formulated in conjunction with consumers of the ILRC (i.e., the primary research targets). The questions were also pre-tested with a group of six consumers. In addition, the survey and interview guide were sent to the Department of the Secretary of State (project funders) for their information and input.

4.4 DATA COLLECTION

Self-administered, mail-out questionnaires were sent to 285 consumers who were on the mailing list of the ILRC in Winnipeg. This mailing list was comprised of both men and women, of all ages and with all types of disabilities. There was no prior knowledge of who had or had not experienced abuse in their lives. This fact was clearly stated in the cover letter. The package that went out also included information on community resources, in the event that the person required assistance in dealing with any emotions brought up through their participation in the survey. Assistance in completing the survey was also made available. The survey was available in regular print format, large print, audio cassette, and computer diskette.

Recruiting Interview Respondents

The survey included an open invitation to participate in a personal interview, a more in-depth form of data collection. The opportunity to participate in a personal interview was open to men

and women, as well as to those who had or had not experienced abuse in their lives. In the case of those who had not experienced abuse, the questions were asked in terms of their perceptions and/or knowledge of the area. Individuals were given the choice of meeting place, which in all cases was either their own home or the ILRC office.

People who were interested in participating in a personal interview were asked to contact the ILRC by phone or mail. They were also given a choice of a male or a female interviewer. An open notice of the opportunity to participate in an interview was placed in the ILRC Newsletter, but no one referred specifically to the newsletter advertisement in terms of how they became aware of the study. Therefore, although we believe most individuals were involved due to their names being on the ILRC mailing list, there was the possibility of participation by people who were not previously consumers of the ILRC. Individuals were not asked how they became involved in the interview process.

Once a list of informants was made, a preliminary letter (see Appendix C) went out thanking people for agreeing to participate. The letter outlined some of the questions that would be covered during the interview, in order to allow people the opportunity to prepare mentally for the actual interview. Due to the sensitive nature of the topic, this seemed to be a fair procedure. Previous individual and organizational trust was also important to the success of the project, in terms of developing rapport with interview respondents, and their being able to trust the interviewer

(i.e., respondents in most cases, had a previous trust relationship with the interviewer, or had a high regard for the integrity of the organization).

This letter was followed by either a phone call from them or from the research coordinator. At this time a meeting was arranged. The choice was given to the consumer, in order for her to control personal safety factors. This contact was used both to set up a mutually agreeable time as well as to offer the person a chance to change her mind about participating.

The Interviews

The interview explored many of the same areas as the survey, but probed for more details. As well, questions in the interview explored more aspects of experiences and knowledge of abuse as reported by people with disabilities. A copy of the interview guide is located in Appendix D.

At the beginning of each interview, a consent form (see Appendix E) was reviewed with the person to be interviewed. Interviews were taped for the purposes of creating written transcripts based on the tapes and interviewer notes. It was agreed that the cassette tapes would later be destroyed.

Data were collected from interviews conducted with eighteen women with disabilities during the period from March 1993 to June 1993. This sub-sample consists only of women with disabilities who, in their interview, had reported having experienced some type of abuse. Of the eighteen, nine had early onset disabilities and nine had disabilities of later onset. Those with early onset disabilities

can be conceptualized as having disability as a major factor impacting on identity-formation (i.e., disability played a major part of their initial formation). Those with late onset disability would have formed some sense of self prior to the acquisition of disability. For these women, disability would be incorporated into their non-disabled sense of self. No other information was used to select respondents for this current research.

The Data

All interviews except one (with Caritas, conducted by another ILRC staff member) were conducted by me in my role of Project Coordinator. The interviews with the women ranged from 1.25 hours to 2.0 hours in length, with an average of about one and one-half hours (1.44 hours). Ten interviews were held in the individuals' homes, seven at the ILRC, and one in another location.

Overall, we received survey responses from sixty-nine individuals. Additionally, the eighteen interviews yielded 185 typewritten pages of transcription.

4.5 DATA ANALYSIS

The methods of data analysis combined qualitative research with feminist research practice in which the research may be used for a more political or action-oriented purpose. A grounded theory approach (Glaser and Straus, 1967) utilizes an inductive method, wherein the researcher observes aspects of social life and seeks to discover patterns.

The process I used in data analysis was as follows. At the

time of the interview, I made sketchy notes and taped the interviews. I later transcribed the tapes and entered this on the computer. I had two versions of the notes. One gave an overall story for each respondent, and the second was organized by the questions asked from the interview guide. I made three copies, so that I could keep one intact, highlight and write on another, and cut and paste on the third. I then compiled a conceptual framework from the existing literature on violence against women. Using the framework as a guide, I sifted and re-sifted through my data, discerning patterns and themes. I looked for both similarities and differences in doing this.

4.6 RESEARCHER ROLE

I was involved in this project from its inception as the Project Coordinator and Principal Investigator. My perspective is one which was influenced by my role as a woman, as an ILRC staff member, and as a feminist.

In consultation with the Abuse Advisory Committee and other consumers, I was responsible for developing the survey instrument and interview guide. I was also involved in administering the survey, and collating and analyzing the results. Coordination and facilitation of a peer support and a focused Independent Living Skills Group was also part of my role. As Principal Investigator, I conducted all but one of the interviews. Additionally, in conjunction with others, I performed a role as educator and consultant on the issues of abuse and disability, in the local community and on a

national level, which gave me numerous opportunities for informal discussions and consultations.

Now that I have presented the methodology used in the study, it is time to move on to Chapter 5 which contains vignettes of each woman and her experience with abuse, created from the interview data.

CHAPTER FIVE: THE WOMEN AND THEIR STORIES

5.1 INTRODUCTION:

This chapter starts with a brief explanation of how the women were assigned pseudonyms. This is followed by condensed life histories for each woman. Finally, there is a short presentation of why the women participated, as well as the demographics of the women in this study.

5.2 NAMING THE WOMEN:

All of the women have been assigned pseudonyms in order to protect their identities. They have been randomly assigned the names of Greek goddesses, demi-goddesses and princesses in order to avoid any relation to real life people. It seems fitting to use as pseudonyms the names of women in Greek mythology, as there is a richness to the stories and the teachings from this era. Also, there are many myths and misconceptions surrounding women with disabilities who have experienced abuse, and hopefully this work is able to shed some light on the complexity of their situations in the same way that Greek mythology is capable of expressing complex meanings regarding the ordinary and extraordinary (Lefkowitz, 1986). It is important to look for the patterns and deeper social meaning in mythology (Lefkowitz, 1986), and in some way this is also the task of this thesis.

5.3 THE WOMEN AND THEIR EXPERIENCES

The eighteen women can be divided into women with early onset disabilities and those with late onset disabilities. There are nine in each group, as listed in Table One.

TABLE ONE: MASTER LIST OF NAMES:

Early Onset:

Respondent No.	1	Electryon
	2	Antigone
	3	Atalanta
	4	Demeter
	5	Athena
	6	Ismene
	7	Helios
	8	Anyte
	9	Hecuba

Late Onset

Respondent No.	10	Amphitryon
	11	Cyrene
	12	Thetis
	13	Artemis
	14	Nausicaa
	15	Atthis
	16	Iambe
	17	Erinna
	18	Caritas

Note: These respondent reference numbers are used in Charts 1-4 and Chart 5 (pp. 164-7, 179).

Women with Early Onset Disabilities

1) Electryon

Electryon, disabled from birth, described what seemed to be a constant barrage of abuse from a very early age. Her disability is described as multiple--she has cerebral palsy, resulting from a lack of oxygen to her brain sometime before birth, and is blind in one eye and visually impaired in the other. Her physical disability is such that she uses either arm crutches or a manual wheelchair for mobility. She also has struggled with depression over the years, and labels this as a psychiatric disability. Electryon felt that taking part in the interview process, talking about what had happened in her life, was an important step in healing.

At the time of the interview, she is thirty years old and single. She lives alone, which, she says, is sometimes okay, while at other times is lonely. She doesn't have home care support, because at the time she could have gotten it, she felt independence meant doing it all on your own, and independence was hard to get. Her sight has been changing (for the worse) over the past year or so, and she says that has made things harder. She is seeing a therapist now, and that, combined with other medical appointments and the volunteer work she tries to stay involved with, occupies her week to a considerable degree. The weekends are difficult, but she usually makes it through.

Electryon is aboriginal. She lived her early years on a northern reserve, which lacked the services, accommodations and understanding she needed to survive. Her parents kept her indoors,

they said, to protect and shelter her from the outside world, although she felt that perhaps it was so that others would not see her (i.e., to hide their shame at having a daughter with a disability).

She said that her experiences of abuse ranged from neglect, both emotional and physical, to verbal, emotional, physical and sexual abuse. She talked about the drinking and swearing and violence that were a "normal" part of growing up, and how she could not escape, because she was not allowed to leave (as they felt she couldn't manage on her own), and there was nowhere to go anyway. She thinks all of the daughters in her family were sexually abused by their father. There was also lots of emotional abuse, being called names and being called down.

Electryon described the abuse she received as her fault. She thought that all of this was happening because of her disability. "If I wasn't like this [disabled], it wouldn't happen." This belief, she says, was confirmed by her siblings, who also blamed her and her disability for family dysfunction such as drunkenness, arguing and constant fighting. She said that her self-esteem was "really knocked down." She related, "When you're told 'no you can't' long enough, you begin to believe it. When you're told 'you are sick,' it takes all your choices away." Because of the abuse, she had no trust in people. She did not like people or like to talk to them. She developed a fear of being judged (and failing to measure up). Later, she found it hard to talk about or think about sex; the more she talked, the more she remembered, and the harder it was. She would sometimes "disappear" for six months at a time. She would hide in

her apartment and not see or talk with anyone.

Even now, at the time of the interview, she says she has a hard time relating to people. She is scared to get close to people. It is hard for her to trust. Even though she "knows better," she doesn't feel that great about herself, and part of her also blames the abuse on her disability. She talks about the feelings going really deep. "I never had that first chance to feel o.k. about myself, and the constant abuse made it harder." The abuse made her life very alone, even to this day. Although she is working hard on self-esteem and confidence, she still spends a great deal of time alone, because "this is all I knew and could feel secure with; sometimes it's better off to be alone."

2) Antigone

Antigone is thirty-nine years old at the time of the interview. She lives in an apartment of her own with support from cooperatively directed resource staff and attendants. She has cerebral palsy and a hearing impairment. She has been disabled since birth. She uses an electric wheelchair to get around and is quite computer literate. She is single and says she has never had a significant intimate relationship. She stays busy with volunteer work and taking courses, such as crafts and computers. She said that the ILRC has been an important force in bringing her life together. "People at the Centre helped me get out to live on my own, and helped me feel good about myself."

She described the physical, sexual and verbal/emotional abuse she began experiencing since she was a little kid, around the age of

three. A lot of that early abuse was from her parents, who told her that these things happened because she (more specifically, her disability) was too much to handle. Granted, they didn't have any supports or respite, but "they just couldn't handle the disability, doing the physiotherapy, and having the wheelchair there." She was not allowed to use her wheelchair at home (she crawled, even at 5 or 6 years of age), because "it bothered people and reminded them that something was wrong" (i.e., she had a disability). She found it very degrading.

When she was growing up, the bathroom was a cause for anxiety. Only her parents could take her to the bathroom. If she had an accident, which would happen since she had to rely on only a couple of people for assistance, they would hit her and lock her in her room all day. This started when she was four. She would hide under the bed all day. Hitting also became part of the routine. Both parents would hit her and call her names. She said, "I don't think this would have happened if I hadn't been disabled." She also felt they had no time for her. No one ever said anything good or nice about her, and that made her "go into a shell more and more."

Her father also sexually abused her from a young age, but she doesn't remember too much about that, other than she knows it happened, it affects her deeply, and she cannot trust too many people as a result.

Antigone said the abuse made her go further and further into herself and her own world. She wouldn't talk to anyone for fear that they would hurt her. As no one ever said anything good or nice about

her, she felt very bad about herself most of the time. Because of the isolation and over-protection, she did not get the opportunity to try things out and experiment with new people or activities. "I was never very social with other people, mainly because I was never given the chance." Later, she was afraid she would say the wrong thing, and therefore still kept to herself. This left her with a lack of social interactions and little chance to develop social skills or social networks. Messages conveyed through the abuse made her feel like she was "very bad and a great deal of trouble, and perhaps I should not be alive." These messages, she said, result in a poor self-concept. It would help, she said if everyone didn't believe that her parents were such perfect people. "To this day, everyone thinks they are martyrs." Her parents won't acknowledge that they did anything wrong.

Because of the abuse and because of the disability, Antigone said it was harder to meet people. This was due to the lack of social opportunities, but also to the lack of self-esteem. The self-esteem problem, fostered by factors related to her disability, was, she felt, exacerbated by the constant emotional battering. She also noted that "being made to crawl around without your wheelchair really impacts on your dignity and respect." She names isolation as a constant feature in her life, and that this was both disability- and abuse-related, and that everything resulted in low self-confidence and self-esteem.

3) Atalanta

Atalanta described herself as being mentally handicapped due to a lack of oxygen at birth. This makes her slow, in movements, speech and thought. At the time of the interview, she is in her 50's and lives with her husband, a quiet man. She has spent a lot of time working in sheltered workshops, which she doesn't really like, but it keeps her working. She likes to help out and drops by the ILRC a lot.

She said "The only abuse I ever experienced was when I was seventeen years old and living in rural Manitoba. I was going home one night when a guy raped me." She said that he just said hello, overpowered her, took her to some room, and raped her. Mentally, she felt she didn't know to be afraid of this stranger. Even at the time of the interview she feels a bit guilty, saying that perhaps she might not have gone so easily if she had known. She blamed herself for it happening. She felt that if she had not been so trusting, or had not felt that everyone was good, it would not have happened. She said that "instinctively I knew it was not right and that it was rape." After he physically overpowered her, he told her that she should be glad (i.e., that someone would "stoop" to having sex with her--he assumed that no one would want her).

She was able to get good support from her parents and the police. She was very scared and stiff, but was believed by doctors and everyone, and that was really important, she said. For a while, she had very low confidence as a result. She never talked to men, as "they made me feel rotten." Now, "I feel I have gotten over it, but it still makes me mad." She cries as she talks about it.

When asked about the effects of the abuse, Atalanta said it no longer affects her as much as it used to. She says that is due to the love and understanding shown to her, and to the supportive people in her life, including her parents. After the incident, she felt quite bad, thinking she had somehow brought this on, and that she should have prevented it. She had very low self-confidence. She recalls that it was really strange that it was dealt with quite openly. "Everyone knew, so maybe the dignity was not as high because I didn't understand what was going on." In hindsight, she says that maybe that kept her from feeling ashamed and dirty, and let her move on.

4) Demeter

Demeter has been disabled since shortly after birth. Her disability, a type of muscular atrophy affecting the nervous system, has led to progressive physical deterioration, and left her essentially quadriplegic. She uses an electric wheelchair and has limited use of her arms and hands. At the time of the interview she was 52 years old. She is single and lives alone. She is now a fairly vocal advocate and is quite involved in her work for an organization doing systemic advocacy in the disabled community. Demeter wanted to participate in the abuse research because she felt she had a different kind of example than most, one which involved a paid caregiver and the government bureaucracy.

Due to her physical limitations, Demeter was highly dependent on orderlies/attendants for basic daily living and personal care needs. This included getting up, clothed, preparing meals, going to

the bathroom, having assistance in bathing, etc. After her mother died a number of years ago, Demeter had to rely on home care services delivered through the provincial bureaucracy. "It was difficult getting used to strange male orderlies coming to my home, but that was the price to pay for wanting to remain in my own home, get out of bed everyday, and be bathed and dressed." The orderlies were all males, and many were not screened (one had been in prison, another had a serious sexual dysfunction for which he was receiving shock therapy). There was also a lack of training, although some on-the-job training is necessary. Even so, some training in pre-employment basics, regarding appropriate and inappropriate behaviour, and so on, could be done.

At one point, she was very depressed, and had a female worker from home care staying overnight. Although she was there, she was not allowed to do her morning routines. Instead, a male orderly was sent. One orderly, who in some ways was a very good orderly, was used more often than others. He had a history of saying things to her that could be construed as "inappropriate," but she explained them away as seemingly harmless remarks. One day this male orderly was giving her a bath, and while drying her off, he "molested me sexually" -- touching her in such a way that was not part of her personal care routine. "I screamed for him to get off, but he didn't at first. I kept trying to push him off, but of course I couldn't. He finally got off and in a surprised voice said he thought I wouldn't mind. I then had to endure him touching me while he finished getting me dressed and put me in my wheelchair. I felt completely

helpless."

She called home care services to report what had happened and to ask for him not to be sent anymore, and that, she says, was when the real abuse began. "They kept sending him to my home despite my repeated requests not to. The choice was between laying in bed all day or letting him help me get up." She said that obviously they did not believe her--at one point they said that the orderly claimed he did not do anything. "It was obvious I was not being believed or it was of no consequence to them if I was telling the truth. After months of raising her concerns through the different levels of different systems, including letters to the politicians, she was given a choice of cooperating or losing her services. She would be required to have a fixed schedule with no room for changes for any reason, which was not adequate. Still, they could not guarantee that that particular worker would not be sent to her again. She told me that "In many ways, I was abused more by the system's response to me than by the original incidents."

Demeter described the effects the abuse had on her as creating anger. She said "This anger was less directed at the orderly who abused me, and more at the bureaucracy which refused to help me." She said, of course it had an impact on her mental health, but she had a good counsellor who was able to help Demeter keep from blaming herself for any of the abuse or how it was being handled. At times, she said her health, both physical and mental, was affected. She felt depressed and tired. However, she was able to get through it with strong determination and persistence. She's not quite sure

how, but "I never gave up on myself, which I feel is often a problem for people with disabilities." Perhaps it was her connection with the disability movement that kept her focused.

5) Athena

At the time of the interview, Athena is a 33 year old woman who lives alone in an apartment. She is a student and a bit of a loner, being very careful about who to trust. Even doing the interview for the abuse project was a major decision with regard to the trust issue. Community college has been a real effort, but she will be done soon. She has worked hard to do well in some very difficult courses. Sometimes her health has not "cooperated" so well. She has cerebral palsy, which has affected her since birth, and she uses arm crutches to get around. This limits her mobility somewhat.

Athena talked about the constant emotional abuse she endured while growing up. Relatives and others raised in the "old days" treated her in ways "not fit for a human being." They would "say and do things which were very hurtful and isolating, including sending you away or treating you like you had a mental disability or that you were stupid." She said that people felt justified in their negative attitudes, and therefore felt their behaviour was acceptable. The justification was that people with disabilities really weren't treated as equals, and you could treat "them" differently. Because it was done by those closest to her, "This left a lot of emotional scars and trust issues -- even to this day."

Up until she started going to school, "I knew I was different,

that I had a physical disability, but I had no negative attitude toward it." However, when she started interacting with other kids, she was often excluded. "They would call me a "cripple" and point out how strange things were that I did, such as how I walked. This was very hurtful. At first, she went to a totally segregated school, which did not have a very accepting attitude. Later, she went to a "so-called integrated high school," and got along well with disabled peers, but "we were marginalized by able-bodied students."

One day, while waiting to go home, she was harassed and touched inappropriately by a group of young men because, "They knew I could not stop them and that they could get away with it." She said it was terrifying. Recently, she experienced inappropriate touch and sexual comments from someone working in the transportation system set up for people with disabilities. She mentioned it, but did not want to discuss details during the interview, as the situation was not yet resolved. She hopes that a lot of this will begin to change as people with disabilities becomes less segregated and the general public becomes more aware. "Maybe people will be less able to get away with treating us badly."

Athena reported that the abuse made it more difficult to trust people emotionally. "Even now, I find myself testing people." Because of the earlier abuse of power, and now that she is older and stronger, she says she tries "desperately to hold my power and not give it up." She won't give it up "Because I had too much taken away before." She says that it is very difficult to keep control in her life since she is involved in so many systems due to her disability. She

says that sometimes she just feels like a number, and that is hard on her self-esteem. She has managed to feel a bit better in terms of the effects the abuse has on her life by being very rational about it, and making herself move on, go to school, etc.

6) Ismene

Ismene is single and in her early thirties at the time of the interview. She lives in her own apartment, and is part of a cooperative living project which involves not only shared attendant care services, but also personal resource supports. Ismene has been disabled since birth, although some facets, such as psychiatric depression, have developed over time. She has cerebral palsy, uses a manual wheelchair, has eye-hand coordination problems, difficulty with perception, and disc degeneration in her back. She is involved in the community, takes courses, actively participates on boards of directors, and volunteers at various organizations and agencies. She is fairly analytical with a lot of things she has to say, and speaks quietly but knowledgeably, demonstrating previous thought on many of the issues.

Ismene talked about the sexual abuse that started in her early teens (around age 14). The sexual abuse was perpetrated by a family friend. "Because of my mobility limitations, I couldn't get away." Although she told her mother about the incident right away, her parents chose not to pursue the matter, as this, she felt, would create difficulty in the relationship with this family friend. The lack of response on the part of her parents was hard to deal with for several reasons. First, he continued to be invited over, putting

Ismene in repeated danger and emotional stress. Second, it "increased my feeling of vulnerability, because even in my own home I knew I could not feel safe or get away." Third, she felt it was important to do something or he could go on to do the same thing to someone else. She also didn't have anyone else to talk to, as "I didn't really have friends, and I didn't get out very often."

She also recalled a rape that occurred shortly after moving out on her own. She was living in a transitional apartment complex. There were drugs and alcohol involved in the situation, which was part of what she described as a whole experimentation process that went on after moving out of a highly sheltered home environment. The guy who raped her made threats about what would happen to her if she told. This involved the threat of physical harm, that he would find her, but also that no one would believe her, because "Who would rape someone with a disability?" It was after this incident that she had her first nervous breakdown.

There were other experiences since then, including sexual harassment, obscene phone calls, being followed, and sexual assaults. She thinks that "A female in a wheelchair is seen as more vulnerable and less able to defend herself."

Relationships have also been difficult. "Things start out okay, but then something seems to happen. They either just fall apart or get dangerous." She remembers the phone being pulled out of the wall in anger, and the fear that caused for her. She thinks that "My own beliefs about increased physical vulnerability may have raised my anxiety." Sometimes "not knowing any better" got her into

awkward or dangerous situations. Because alcohol was involved in some of the incidents, she said she felt extremely guilty. Through it all, she was quite alone. "When I asked for help, what I got was blame, and that led to my feeling suicidal." Counselling was hard to find, and much of it was physically inaccessible to her.

Ismene said that the biggest effect for her was fear. She became afraid of men. She was also really disillusioned regarding the possibility of "nice" relationships. "Trust was, and continues to be, very difficult for me to feel." She was able to talk to family members and social workers, but she still felt very alone and very bad about herself. Some of the issues were not dealt with because staff did not want to "rock the boat," and this made her feel "less deserving." Her self-esteem and self-confidence are low, but she wonders if they were ever high, even before some of the abuse. This she attributes to her disability and how she never felt like anyone wanted her to be alive because of it.

7) Helios

At the time of the interview, Helios is a 30 year old, single female who lives alone in an apartment, but with partially shared attendant care staff. She has cerebral palsy which has affected her since birth. She uses an electric wheelchair and has somewhat limited use of her hands. She also has persistent bladder and bowel problems and a learning disability. For the last ten to fifteen years, she says chronic depression and feelings of wanting to commit suicide have been issues for her. She has had to battle against feelings of inadequacy and low self-esteem. She feels that coming

to the ILRC and doing volunteer work has really helped her to feel better about herself. She also noted that until she did the abuse survey, she had not even thought of some of the events in her life as anything out of the ordinary. She noted that "Many people with disabilities assume that because things are ordinary, such events are normal."

The experiences she described began at a very young age. She started by saying that "disability has always been a real problem for my family and still is. They have never accepted my disability, and think that if I just tried harder, I could walk and talk normally." She says she was subject to a lot of emotional and verbal abuse because of her disability and the lack of acceptance of it. She was repeatedly told how being disabled was the worst possible thing and was a sign that she was cursed. Threats were also made that if "God didn't strike you down, I will ..." There were many occasions on which her parents would tell her that they would all be better off if she were dead, and that all of their hardship was the result of her being disabled.

Their house was inaccessible, so she was limited in her ability to move around or get out, particularly on her own. Within the house, she remembers things like "Being held at the top of the stairs and being threatened with being pushed down the stairs, in order to teach me to walk." She said she was very socially isolated and had no one with whom to talk.

On a physical level, she also experienced what she now sees as abusive behaviour, directly related to her disability. She had her

fluid intake extremely restricted because it was a "hassle" to take her to the bathroom. She was made to feel bad for incontinence. "I was called lazy, and beaten if I had 'accidents.'" She said that her incontinence was also mocked her by her classmates.

As she was growing up, she was also subjected to "neglect, physical beatings, and sexual abuse." She lived with the sexual abuse because there was no getting away and because of what she now called a "perverse need for any kind of attention or affection." Some of the incidents, especially with her mother, involved what she called satanic and cult-like rituals. She also remembers her father threatening the family with a gun. She believes that all of the children in her family were abused. "It was bad for everyone. My brother never spoke and eventually committed suicide."

She says that "Not having anyone to talk to, and not having any positive role models regarding people with disabilities, made it harder than it had to be." She smiles though and says that "It is kind of hard now, but I am getting there." She is trying to come to terms with the fact that those events which occurred while she was growing up were not her fault.

Helios said, "I remember growing up and hearing constantly that being disabled was the worst thing in the world." She said it was really hard to think anything different, particularly in the absence of someone with a disability to look up to as a role model. "As a result of the negative messages, I grew to believe that everyone would be better off without me." As a child, she said she spent lots of time crying and in fits of rage. "I remember being very

destructive -- smashing things, head banging." She was also suicidal. She tried slashing, and she tried to choke herself to death at the age of 14. To this day, Helios reports that she has very low self-esteem and not a lot of confidence in herself. "I think this is due to the emotional abuse and messages she received about having a disability." She says this has improved in the last couple of years, but there is still a long way to go.

8) Anyte

Anyte has had cerebral palsy since birth. She also has sclerosis of her spine and severe asthma. She has also been involved with the mental health system because of depression and feelings of suicide. She is twenty years old at the time of the interview, single, and living with friends. She will soon be moving out with new roommates. She uses a manual wheelchair to get around. She has just finished high school.

She is of aboriginal descent. She has not lived with her biological family very much. When she was born, medical care on her northern reserve was limited, so she was flown back and forth between her home and Winnipeg. When she was at home, she would be neglected by the family. "Because of my disability, and not knowing how to meet my physical needs, they also assumed they could not care for my emotional needs." When she was five, she moved to Winnipeg and lived with a foster family so that she could go to school. Her biological family would never agree to adoption because they were afraid they would never see her again. However, she did not have much connection to them.

"I lived in two worlds and felt part of neither." She would go back to the reserve for visits, but her biological family was "drunk, fighting and neglectful" and her needs would be totally forgotten. However, even in foster homes, she described abuse, fighting, hitting, and caregivers talking to her like she was worthless. "I would be hit with straps and spoons and called down quite frequently." She felt that many of the foster families were "only in it for the money, and I was paid for at a higher rate because of my disability." By the age of eight, she learned to block out her feelings, and never really talked to other people.

She was raped about a year before the interview and then was sexually assaulted again not long after that. These incidents "Brought up memories of being sexually molested when I was younger." She wasn't believed because she was "just a kid with a disability." Thinking about that, she noted that "Because you have a disability, there are more systems involved and systems are often barriers to getting help or being believed. No one sees you as a real person." She feels like she was able to get some support for the more recent sexual assault, but as the negative experiences add up, she wonders if she will ever be able to have a "normal" life.

Anyte says that "My past significantly affects my present and my future," both directly (in the form of flashbacks) and indirectly (in terms of how she feels). She says she has extremely sensitive feelings around trust. She is scared to let people close to her, because the message she has received is that "I love you, but I will also turn around and say I don't like you and I don't believe you." She

also learned that "Those closest to you will leave you or push you away." She is very afraid of how people will perceive her life, and is very careful of how much she says and who she tells. "I keep my answers vague in order to protect myself from further harm." She too says she feels low self-confidence and self-esteem, and that she never really was given a "fighting chance." She has always had people tell her what to do, how to do it, when, etc. Because of her disability, she was never given the chance to experiment, and she feels that that has "stunted" her growth and development.

9) Hecuba

At the time of the interview, Hecuba is 39 years of age and is newly living with her male partner. She is working full-time, but making ends meet is a real struggle. She has spina bifida, which results in a slight mobility disability. It affects her balance, making standing, climbing, carrying, and sometimes walking a bit difficult. She decided to take part in the interview process as part of her healing process. Part of the negative impact of the abuse was from keeping it a secret, and so she says she needs now "to keep telling my story."

"Three years ago, memories of my father sexually abusing me as a child began surfacing." Her father sexually abused her at various times from the age of six to twenty-one, when she finally left home. Because of the emotional impact of it, "I was somehow able to block it from my conscious memory through different types of dissociation, but due to counselling that was now ending and I am having to deal with the memories." She also talked about what she

called the emotional abuse and emotional neglect she experienced from her parents because she had a disability. For example, she was left alone a lot in order to make her more independent. Either they wouldn't let themselves get too close or they would leave her alone to toughen her up or make her independent. They also gave "negative messages about disability." She also felt taken advantage of by her siblings and others, and felt this might have been related to her disability.

She also talked about sexual exploitation by a male counsellor she was seeing. "We had some sort of 'relationship' for eleven years." She recalls that "It felt loving and like something I needed. She still struggles with this. However, in hindsight, she feels that "He took advantage of me by not allowing me to take care of myself. He knew I was really vulnerable. That was why I was in therapy." She was eventually able to move on and find another therapist, a feminist therapist, and things are really happening now.

During those years of abuse, and even now, she felt she had no self-esteem. "I never felt good enough, or always felt like I was doing something wrong." She felt a great deal of insecurity, had trouble reading and concentrating for any length of time (from the dissociation), and had no motivation because of the lack of self-esteem. There was a lot of anger there. Because she was never feeling good, she did not achieve well either in school or socially. With the abuse involving the counsellor, it was very much the same, "but very enmeshed; I had terrible boundaries, and mistakenly thought I would die without him." The lack of self-esteem

translated into a lack of motivation to do much of anything. She sees healing as an ongoing process, which may never be over. What she aims for is an integration and acceptance of the abuse and its part in her life.

Women with Late Onset Disabilities

10) Amphitryon

Amphitryon is a woman with late onset disability who was beaten up by male partners or boyfriends both while non-disabled and also when disabled. She became quadriplegic in a car accident a number of years ago. Most of her life was lived in rural Manitoba, but in order to secure the medical and support services she required, she moved to Winnipeg. She is about 38 years old at the time of the interview.

She is living alone in her own apartment, but shares attendant care with other people living in the block. She describes herself as single, although she was married at one time, and also has a boyfriend "Who is sometimes in and out of my life, depending on how things are going." At the time of the interview, things are on the "outs." Physically, she is quite limited in what she can do. Due to the car accident, she uses a wheelchair and has only limited use of her left arm. She says she is not able to do much with her hands anyway as they are pretty well closed. Despite this, she does a lot of volunteer work and keeps pretty busy. In fact, she is quite adamant that you need to "keep smiling and just keep going."

She described the verbal, physical and sexual assaults that

were a significant part of her life, both before and after becoming disabled. Often these events were connected to drinking binges on the part of her partners. "My attendants threatened to leave me if I didn't do something about my abusive husband's presence, as he was verbally abusing them too." She felt that she had the confidence and learned to fight back when she experienced abuse prior to becoming disabled. Her previous experiences with the police and other helpers were good, so she felt she had enough confidence in them to utilize them again, even after becoming disabled. In fact, "I felt that they responded even more quickly due to them seeing me as helpless and vulnerable because of my disability."

At the time of the abuse incidents, she said there was a great deal of arguing and screaming. Her partners also beat her and made numerous threats. Amphitryon said these events made her unhappy and gave her a "sore heart." She said that she was very isolated and, "At first I didn't tell anyone because I felt they would not understand it." She felt this was because the people she could tell would either not understand about the disability or else about the abuse. After the car accident, she said "It was really hard to deal with the abuse and a new disability at the same time." Her husband made her feel like she was really bad. "In fact, maybe I deserved the abuse." She remembers feeling like she was lucky to have anyone -- especially because he also helped her do other things, such as eat or get in and out of bed. "I already felt a bit useless because I couldn't do anything; this made me feel worse about me -- in terms of self-confidence and self-esteem."

11) Cyrene

Cyrene is 69 years old at the time of the interview. She is a widow who lives alone. At the time of the interview, she had been in Canada for just over ten years. She came from the Philippines, and feels that a lot of people don't like her because of that. She lives in her own apartment in a seniors' block. She lives comfortably, as she has "resources." "I feel that others are jealous of me because I can live comfortably." She has a late onset disability which has affected her for more than five years. She has not really adjusted to it yet. She is somewhat paralyzed on one side due to a brain tumour. She has heart problems, high blood pressure and diabetes. She uses a scooter to get around because of her limited arm use, balance problems, and because she tires easily. She says that she doesn't believe people with disabilities can do much on their own.

As a woman who has fairly recent mobility limitations, she talked about emotional and psychological threats that she saw as related to being of non-white background. She feels that "People think they can get away with the discrimination, name-calling and threats because I cannot fight back [due to her disability]."

Sometimes she is really scared on the streets, and also within the building where she lives. This is particularly the case when the men in the building are drinking on a Friday night. She feels that a woman with a disability is particularly vulnerable. "They could do anything to you."

She has had threats of physical harm made to her in person and

over the phone. "People try to exploit you or scare you because you are disabled and coloured," she said. She was sure the obscene phone calls and harassment would not have happened otherwise. At first, she didn't call it abuse, but later she felt that it was exactly that, and that it was not right. Overall, her description was one of living in a constant state of fear and vulnerability. "I feel it is unescapable. They will get you sooner or later."

Cyrene described the effects of the abuse as making her feel hurt and scared. She also said it made her feel like she didn't belong because she walked differently. There aren't many people she now trusts, because she believes "most people will try and hurt you or take advantage of you if given the chance." She feels that her disability makes her more vulnerable, and this adds to her fear and general uneasiness. Overall, she said the abuse made her feel disappointed in the state of people. She tries not to take it too personally, as she says she is old enough to know better than to take in everything that others say to her. It seems that she already had a well-formed identity and sense of self prior to the abuse, and this, she said, helped moderate its effects.

12) Thetis

Thetis is a woman who has become progressively more disabled over time, due to chronic and progressive physical and psychiatric disabilities. At the time of the interview, she was 38 years old. She lives alone, in an apartment in central Winnipeg. It is a low income block and she says she both likes and dislikes it. She feels she gets exploited by some of the young women who exploit her

for babysitting purposes, yet she likes that they depend on her; it makes her feel important. She also really likes the kids, although because of her arthritis they easily tire her out. She is single, and thinks that will always be the case. Sometimes she uses a wheelchair, and hopes to get a scooter; sometimes she walks. She has chronic pain, which compounds the depression which has been part of her life for quite a number of years. Her psychiatric disability began when she was in her late teens to early twenties, and the arthritis has progressed throughout her adult years. She is involved in things, but very much subject to her level of energy and pain.

When she was just a child, aged nine or ten, she was sexually abused by her uncle, who was a school bus driver. He used to take her out for drives and would fondle and sexually abuse her (i.e., have intercourse). This continued until she got her period. She blames her psychiatric disability on the abuse. She was put into a psychiatric institution during her teens, and there she was also abused by staff--"verbally, physically and medically." Medical personnel just tried to give her more medication so that she would feel happier. They did not deal with her concerns of verbal and physical abuse. She also saw some other things as abuse, including having no control over treatment or medication, and being told to just "take it and be quiet." She also watched other people being physically, sexually and emotionally abused, which added to the feeling that you are always a target.

She was in and out of foster homes, group homes and

institutions. "Foster homes were hard to get because of the stigma of mental illness." As an adult, she had her own apartment, and started going out with a man. He raped her. Her doctor discouraged her from reporting it, saying that she would not be believed (because she was "crazy") and that she would just get put back on the psychiatric ward. She said, "The invalidation and lack of credibility, due to my psychiatric diagnosis, is also a type of abuse."

She also talked about what she called "medical abuse." Some instances she mentioned were being put on Depo Provera for birth control because it was easier, having her tubes tied because she should not have children (because her mental health problems might be genetic), and general discounting of her feelings, questions and concerns. She said that medical personnel ignored the side effects of medications, would not believe her chronic pain, and so on.

As well, she also talked about the verbal and emotional abuse she experienced most of her life from people who didn't understand her disabilities. "This ranged from bullies pushing me around and calling me names, to people not wanting to associate with me because I was always depressed and crazy."

Thetis, at the time, felt like the "black sheep" of the family. Some of this, she said was because she was not married and had no kids. They also "Kept bringing up old memories, and made me feel I was wrong or had deserved everything." She related that "between my disabilities and the abuse, it was really hard to feel good; both battered my self-confidence and self-esteem; I never really ever had a chance to develop a good sense of who I am." She also felt that

both the abuse and her disabilities brought her into a great deal of contact with medical personnel; this created a dependency on workers, which she said also made her have a hard time letting go of people.

13) Artemis

At the time of the interview, Artemis was, she says, "41ish." She is single, although she was married at one time, but her husband left when the multiple sclerosis (M.S.) started getting bad. She has two grown daughters, but sees one only rarely and does not see the other at all. She lives alone, in an apartment downtown. She has access to shared attendants, which allows her a fair amount of freedom. She uses an electric wheelchair. She has no hand-eye coordination and is legally blind. She also has sleep apnea which affects her energy level, especially later in the day and early in the morning. She has late onset disabilities, which began to affect her significantly in her early twenties.

Artemis described a lifetime of abuse. Some of this, but not all, she felt was related to her disabilities. "Both parents verbally and physically abused me from an early age, and threatened to send me away to an orphanage." This left her with no self-confidence or self-esteem. Later, after the onset of her disability, she was sexually assaulted three times, in what she describes as "strange stuff." One incident involved a man who stalked her and would corner her and masturbate in front of her because he knew she couldn't get away. A second involved a guy who cornered her in a bathroom in a mall, hung over the top of the cubicle and watched her,

leering, laughing and harassing her. A third incident involved a man throwing himself on top of her and "molesting" her. In each situation, she felt limited in her ability to "fight back, escape, or cope," due to her restricted strength, vision and mobility.

Artemis began talking about the effects the abuse had on her by saying "the effects today can't compare to the feelings of three to five years after those days." Then, she was full of self-blame ("I asked for it"). Since then, she has gained more life experiences and formal education, including going to university, and she says this has helped her realize the larger picture. Because of that, and involvements with the women's community, she knows that she is "basically a good person and a nice person." This is very unlike how she felt shortly after the emotional abuse, which left her feeling very alone and not worth very much. She feels that as she ages, "I know myself better and can be more free from the blaming mentality which was an earlier part of my life." She said it was also hard to have other people in denial about the severity of the abuse. "You can get beaten up, but if you don't die [i.e., if it's not bad enough] then it's no big deal." At the same time, she remembers the difficulty she had in dealing with the onset of her M.S., when they "were not allowed to talk about the M.S. because it might upset my mother." This, she said, was very discounting for her, as if it (her disability) were the worst thing that could happen in life. That didn't make her feel very valued at the time. She says that the support she received from community agencies helped to compensate for the lack of family support, and this helped her feel better about herself and

make the necessary adjustments.

14) Nausicaa

Nausicaa was 38 years old at the time of the interview. She has lived most of her life alone, but is currently living common-law with her male partner in a small but homey apartment. She says life has been much better since they have been together. She is less lonely, and less prone to "going over the edge." They also eat a lot better, because he does the cooking and makes sure that food is a priority. Nausicaa has a psychiatric disability. Sometimes it is labeled manic-depression, sometimes chronic depression or borderline personality, but most often she is labelled as having schizophrenia.

She has a routine of where she goes and what she does. She moves about having coffee, visiting, doing volunteer work, and writing poetry or doing creative photography. Having coffee and cigarettes is very important. She comes to the ILRC because both can be done there. She wanted to participate in the study so that she could "help other mentally ill people." She also saw it as important to educate caregivers, so they can help properly.

Nausicaa has been in the psychiatric system for a long time. During that time she says she has experienced a lot of physical, emotional, sexual and financial exploitation. These experiences included threats of being given broken legs unless she had sex with a man; taking advantage of her welfare cheques; stealing cigarettes from her; getting harassing and obscene phone calls from people wanting either coffee, cigarettes, or sex; and many other instances

of rape or taking sexual advantage of her. The perpetrators were caretakers, other psychiatric patients, or just people she met on the streets.

A lot of this she blamed on herself. "At times I was sick or lacked the will power to stick up for myself. Sometimes alcohol was involved. Sometimes I needed money or food and got into bad situations as a result." Also, up until recently, she says she never knew what a healthy relationship was about. She also noted that due to poverty and the psychiatric system, she is forced to come in contact almost exclusively with people who continually take advantage of her. It is hard to break away from those people who victimize her in her neighbourhood and in the hospital. Now she says it is hard to trust and believe that people honestly like her for who she is. She has also struggled to find employment, but encounters, on a daily basis, what she refers to as the stigma of having a mental health problem.

Nausicaa talked about feeling totally worthless as abusive incidents kept happening to her. She felt like she brought these things on herself and that there was no place to which she could escape. She recounted that she had a lot of self-hatred at the time most of the abuse was happening. She also felt very alone and very shameful. She also said "No one would believe me and everyone would blame me." She was suicidal and self-mutilating. She has found it hard to enjoy sex physically and emotionally, but has finally found someone she can trust to be in a relationship with, and she says that helps.

15) Atthis

Atthis was 48 years old at the time of the interview. She used to be married, but her husband "kicked me out when I needed a wheelchair." Now she is divorced. She has two sons, who are usually supportive. She uses an electric wheelchair because of the multiple sclerosis which got bad in her mid- to late-twenties. She also has very bad eyesight due to diabetes, and really high blood pressure, which limits how much she can do. Her speech is slow and not easily understood, as her words come out a bit slurred. She lives alone in an apartment with the support of home care services.

Atthis was raised in a foster family, and remembers abuse at an early age. She recalled that at the age of three, she was told by her foster mother that she would "grow up to be a slut like her real mother," and she and the other kids used to get beaten up all the time. When she got married, she said her husband was verbally and emotionally abusive and then began physically abusing her. "He would call me down, play mind games, and hit me." When her disability progressed so that she needed a wheelchair, he took the kids, kicked her out and got a divorce. "He just couldn't accept the wheelchair."

Since then, she has had three boyfriends who, she says, have all been abusive. One would become physically abusive after drinking, which was quite often. Finally, after he broke a lamp over her head, she ended the relationship. A second was verbally abusive, and she also discovered that he would put her to bed and then "run around and have affairs with other women." A third left her feeling

very vulnerable emotionally, with constant put-downs and physical threats, such as smashing the phone against the wall, etc. This has left her feeling like maybe she is better off alone. She also tried calling the police at various times, but experienced difficulty when they assumed, because of her speech impairment, that she was drunk and not to be taken seriously.

Atthis has low self-confidence and self-esteem because of the abuse. In fact, she doesn't know how much she ever had in the first place, but it was "all crushed by the abuse." She wondered how she seems to attract the same types: "I always manage to get involved with guys that put me down -- I've had three since my marriage." Now, she just stays clear of everybody, because "I don't really trust anyone, including myself."

16) Iambe

At the time of the interview, Iambe was 65 years old and widowed. In some ways, she felt her husband's death was a happy event, as she was always scared of her husband. She also felt that he worked her far harder than was healthy for her and her disability. She lives alone in a block of seniors' apartments. The apartment is nice, but she complains about the gossip and pettiness that goes on amongst the residents. She has extremely bad rheumatoid arthritis, the joints are damaged beyond repair, despite sixteen surgeries to try and deal with the effects. She uses a scooter most of the time, but also has a cane and a manual wheelchair. She finds it hard to do a number of things, including steering the scooter and opening doors due to the limited dexterity she has in her hands. They are basically

knotted up and closed from the arthritis, which began to appear in her late teens.

Iambe described abuse in her life both before and after the onset of her disability. Early abuse included emotional abuse and neglect from her parents. She was constantly reminded that she was an unwanted child. She felt they only took care of her basic needs such as food and clothing because they had to. She said, "My childhood was spent feeling unwanted and unloved. I was always picked on when I was growing up, and was often put in the middle between my parents." She felt like an "ugly duckling," who was not seen as normal. She said she always felt different. She never really talked with others, nor was she close to other people in her family or her community.

She also talked about being sexually assaulted and abused during the war years. She said that "The soldiers helped themselves, and used and abused many young women." Her sister's boyfriend raped her and gave her a venereal disease when she was thirteen years old. She could never tell anyone because she did not think anyone would care or believe her.

When she got married (to a man she did not love), she did so to escape her parent's home. Once married, she was very isolated out in the country. She said "I was made to work very hard in order to properly 'serve' my husband," which, she feels, contributed to how bad her arthritis is today. "No one believed my physical pain, and people accused me of being lazy or said I was making it up." This, she said, is a difficulty with a fairly hidden disability such as

arthritis.

Her husband was also very abusive verbally and emotionally. He did not treat her well, calling her down and threatening her. He was very possessive and would have her followed when she went for groceries or on errands. He would become enraged and verbally and physically attack her. "Those things cut deep. Even today I feel hurt, defenseless, and lacking in self-confidence." However, as she finds out more about others' experiences, she relates that she gains more "positives" in her life.

Iambe says that others never believed her about the abuse, even now. Her children, for example, think that everything was fine. She was overprotective of her children because she feared that the same things might happen. In terms of effects, she never felt wanted or loved. She also felt that because no one took her disability seriously, they did not value her or her health. She has found it difficult to be trusting, and feels very defensive. Due to her low self-esteem, she reports that she tends to take things very personally. Today, she is a loner and tries to avoid cliques and other groups of people who talk or gossip about others. In many ways, she doesn't want to talk about the past, as she is scared of the opinions, of what other people have to say. This is because "What has been said in the past has minimized my experience, devalued my existence, and made me feel badly." She was kept very isolated during the abuse by her husband, and now she keeps herself separate from other people.

17) Erinna

At the time of the interview, Erinna was a 38 year old woman who was then single after leaving, first, a physically abusive husband, and then second, a physically abusive common-law husband. Although she lives alone in her apartment, she has developed a collection of friends, either in the building or close by, who work together to support each other and help one another out. She has very severe asthma which is very limiting. She also has epilepsy as well as a psychiatric disability which has never been given a specific label. She considers that she has late onset disability, as the effects were not major until her late teens and early twenties. Erinna tries to get involved with the community as much as she can. She has tried volunteer work, but has not been able to keep up with it because of her physical limitations. To her, life often seems like a cycle of paying bills, games with welfare and doctors, and buying another pack of smokes.

Erinna talked about a number of abusive incidents in her life. During her childhood, she was subjected to constant name-calling by her parents. She was told she was stupid and would never amount to anything. She also lived in real fear of her father. Her father sexually abused her at various times from the age of six to age twenty-one, when she left home. "The abuse in the household was quite frequent, especially on weekends when my father was drinking." She recalls the hitting and kicking, and being thrown downstairs during some of his rages. On one occasion she was thrown outside during the winter with no clothes on. She watched

her sister and mother also get beat up; she watched him hold a rifle to her mother's head. She said "I guess you could call it an abusive environment."

As an adult, she felt she was drawn to partners who were similar to her father. Her first husband, forced her to work the streets (i.e., prostitution) and also called her down a lot. The other, a common-law husband, would hit her and throw things at her. He would then blame his temper on her seizures. There was far less safety at home than with strangers. A lot of this she just saw as natural for men. "I thought that women were owned, like property or things." In 1991, she was raped by the friend of a neighbour. She said "I would have been more wary had it not been the neighbour's friend. I let my guard down because of that."

Erinna said the abuse affected her by scaring her and making her feel defenseless. She felt like "I couldn't stop it from happening." She also said it was very traumatic, and that some of the trauma was worse when it was her mother who was being beaten. Somehow it was easier to deal with when it was herself who was being abused. Over the long term, she says that she slowly began to feel that "This was the kind of treatment you deserved as a woman." She also learned that there was no use calling the police, because many of them saw it as a private matter and wouldn't do anything about it. She developed very low self-confidence and self-esteem. She said she almost preferred to be isolated because she trusted no one. Above all, she had a furious, uncontrollable anger which burned deep inside. Workers in the psychiatric system said

she had to keep her anger under wraps because it was "unhealthy."

18) Caritas

Caritas was forty-five at the time of the interview and has been separated from her husband for two years. Part of the reason for the separation, she feels, was his inability to cope with her disability, multiple sclerosis. This is a late onset disability, which began to get bad about twenty years ago. The M.S. necessitates the use of an electric wheelchair, and she needs some help with personal care and meal preparation. In addition to the abuse perpetrated by her son, she also experienced abuse at the hands of her ex-husband, but chose not to discuss it in any detail. Most of the time she lives alone, but her 16 year old son also lives with her part-time.

Much of the abuse Caritas talked about was connected to this grown son who lives with her. Her son would often "verbally abuse me and swear at me in order to scare and intimidate me." She says he does not show her any respect. "He would also steal whatever little money I had, or items such as the V.C.R. which he would sell or pawn." He badgers her for money until she just gives in. "He's never hit me or anything, but he just won't leave me alone until I give it to him." She said that, "He yells, throws things, and hits the walls if he doesn't get his way." She tolerates it because "I am afraid that I will be left totally alone." She says "that might not be a bad idea," but at the same time it terrifies her. She might not be able to get by on her own, and "services such as home care are not that easy to get, especially if you do not need a lot of help."

She has other children, but says they are of no help. They say

it is her responsibility, which makes her feel totally alone. She feels alone much of the time. "No one pays any attention to me. They didn't even come over for Mother's Day -- none of them (they all live in Winnipeg). They all just take advantage of me. Everything's more important than their mother." She says this matter-of-factly, not with bitterness. She also tried going to the police for help, but felt they did not want to do much. "They just turned me in the direction of Family Services, and there was not much they could do."

Her health is deteriorating and getting worse. She thinks it is all related to the stress. She cannot sleep at night. Lots of times she is still awake at 3 a.m. wondering what to do. She has had a counsellor and talking has helped. But really "I guess it's up to me to take a stand and find a way to enforce things. But I don't know how." She says that her disability allows her son to do more to her. "He knows I can't run after him and stuff like that. He knows I can't do anything, except call the police, which I have done" (sad laugh). She also feels like she has no control over what is happening. It seems that there is nothing she can do to alter the course of events. So, as time goes on, things just get worse.

5.4 REASONS FOR PARTICIPATING

These descriptions, although brief, convey some very real and disturbing experiences. The women who shared these stories did so hoping that others would feel less alone and less at fault. Most talked about the benefits of breaking the silence and the importance of beginning to define these events as abuse, instead of seeing these

as day-to-day events which were deserved.

When asked why they participated in the interviews, the women generally spoke of personal healing and validation, and a belief that they might, in the telling, be able to help others. Ways of helping included: letting others know they were not alone, increasing the knowledge base (of abuse and women with disabilities), mapping out the wide range of abuse, and educating caregivers. Due to the important role played by the ILRC in increasing the independence and control of many of the women in the study, a number of women also mentioned being of assistance to the Centre. Other reasons, which were a bit more unique are also mentioned herewith. Artemis, for example, agreed to participate in the interview because of the validation that telling one's story results in (if there is a good listener), and because even just doing the survey, breaking that silence, has done immeasurable good. Athena had no real expectations of the interview process, but felt that it was important to talk about things, particularly those that don't always get labeled as "abuse," in order that change will happen. Antigone took part in the project because she "got rid of some of the hatred I've got by being able to talk about it.

5.5 DEMOGRAPHIC PROFILE OF THE SAMPLE

The following demographic information gives a brief overview of the women who participated in the study. For references to the respondent numbers, please see Table One (p. 124).

MARITAL STATUS:

Marital status is shown in Chart One (p. 165). In this sample, nine women were single, three were married or living in a common-law relationship, two were widowed, and four were separated or divorced. The distribution is even more interesting when broken down by early versus late onset disability. For the women with early onset disability, seven were single and two were married or living common-law. For the women with late onset disability, three were single, none were married or common-law, two were widowed, and four were separated or divorced.

In this sample of 18 self-selected women, the most striking features are the number of single women with early onset disability, and the number of separated or divorced women with late onset disability. Women with early onset disability in this study, it would seem, are more likely to be alone. On the other hand, women in this study with later onset disability may be more likely to end up divorced or separated.

LIVING SITUATION:

Living situation is described in Chart Two (p. 165). Most of the women in the study live alone. Eight of the women live alone in the community without supports. Five live independently, but in a supported housing situation. Three are living with a partner. One is living with friends, and one has a dependent teenage child living with her.

CHART ONE - MARITAL STATUS

RESP. #	SINGLE	MARRIED/ COMMON LAW	WIDOWED	SEPARATED/ DIVORCED
1	*			
2	*			
3		*		
4	*			
5	*			
6	*			
7	*			
8	*			
9		*		
10	*			
11			*	
12	*			
13				*
14				*
15	*			
16			*	
17				*
18				*
TOTAL	10	3	2	4

CHART TWO - LIVING SITUATION

RESP. #	LIVING ALONE	LIVING WITH PARTNER	LIVING WITH FRIENDS	LIVING WITH DEPENDENT CHILD	LIVING IN INDEPENDENT SUPPORTED SITUATION
1	*				
2					*
3		*			
4	*				
5	*				
6					*
7					*
8			*		
9		*			
10					*
11	*				
12	*				
13					*
14		*			
15	*				
16	*				
17	*				
18				*	
TOTAL	8	3	1	1	5

DISABILITY:

The disabilities of the women are shown in Chart Three (p. 167). Fifteen of the women had some sort of mobility disability which limited their movement and necessitated the use of wheelchairs, scooters, crutches, etc. Three were blind or visually impaired. One had a hearing impairment. One had a mental disability which she distinctly called a mental "handicap." One woman had a learning disability. Seven women had psychiatric disabilities of one type or another. Finally, one woman had another, undisclosed, disability. The distribution of disabilities is not cumulative owing to the multiple disabilities of several of the study participants. It is also important to note that the women had a number of other health considerations or limitations, such as diabetes, limited hand movement, speech impairments, etc.

AGE:

The age distribution is given in Chart Four (p. 167). In terms of age, at the time of the interviews, there was a range from 20 years of age to 69. Most (10) were in their thirties. Three of the women were in their fourties. Two women were in their fifties and two in their sixties. The average age was 42 years old.

CHART THREE - DISABILITY

RESP. #	MOBILITY	BLIND/VISUAL IMPAIRMENT	DEAF/HEARING IMPAIRMENT	MENTAL HANDICAP	LEARNING DISABILITY	PSYCHIATRIC DISABILITY	OTHER
1	*	*				*	
2	*		*			*	
3				*			
4	*						
5	*						
6	*					*	
7	*				*	*	
8	*						
9	*						
10	*						
11	*						
12	*					*	
13	*	*					*
14						*	
15	*	*					
16	*						
17						*	
18	*						

CHART FOUR - AGE

RESP.#	20's	30's	40's	50's	60's
1		30			
2		39			
3				56	
4				52	
5		33			
6		33			
7		30			
8	20				
9		39			
10		38			
11					69
12		38			
13			41		
14		38			
15			48		
16					65
17		38			
18			45		
TOTAL	1	10	3	2	2

The vignettes provide a brief history of the women, including some basic demographic information, information about their living situation, and a short description of their experiences with abuse.

Now that the women have been introduced and basic demographics examined, it is time to move on to the data analysis in Chapter Six. The key theme areas will be: describing the experiences of women with disabilities, predisposing factors, impacts of abuse on the women, and interventions.

CHAPTER SIX: "EASY PREY": ANALYSIS OF THE ABUSE OF WOMEN WITH DISABILITIES

6.1 INTRODUCTION

In this chapter, I will describe the key themes of the women's experience of abuse. This includes the problematic nature of defining abuse, as well as the factors that predispose women with disabilities to experiencing abuse in their lives. The discussion then moves to consider the impacts of abuse on women with disabilities in this study. Finally, I examine some of the possible sites for intervention in the abuse of women with disabilities.

Although I did not specifically ask questions related to the conceptual framework, as this study was formulated after the data were collected, my study provides some important information gleaned from the interviews. As I analyzed the violence against women literature and considered my data, it became apparent that Figure One (p. 73) captures most of the important variables,for the women with disabilities in my study, although there are some differences, which will be incorporated into a new conceptual framework.

It should be noted that the women in my study were not homogeneous in their experiences, nor are their experiences necessarily reflective of the experiences of all women with disabilities. Women with disabilities differ in terms of types of disabilities, types of abuse experienced, types of life experiences, etc. Women with disabilities, as all women, have a diverse range of

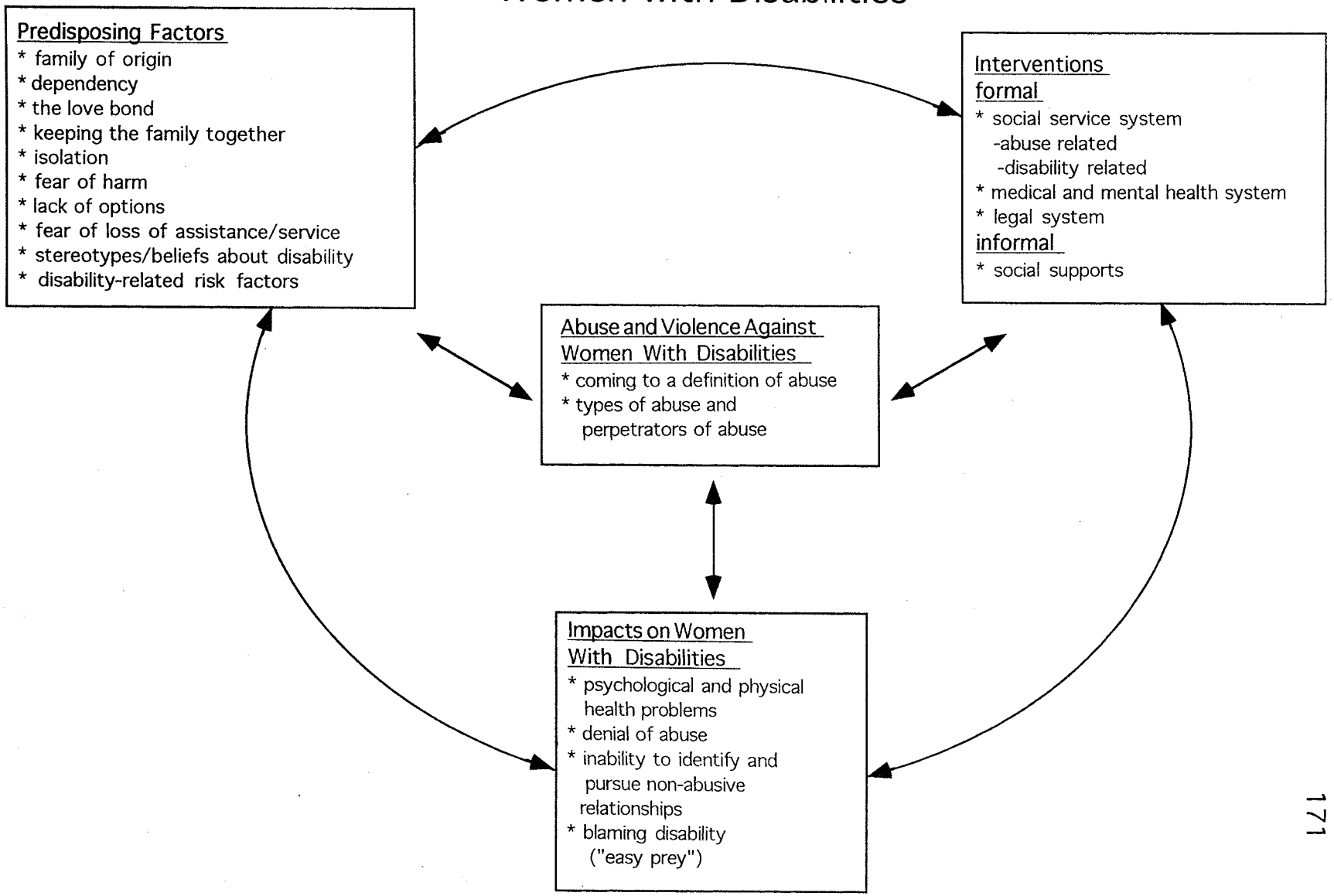
experience, which may have differential effects on their experiences of abuse. This heterogeneity may not always be apparent as I go through the analysis, due to my attempt to highlight patterns or themes, as opposed to focusing on each individual case.

6.2 THE REFORMULATED CONCEPTUAL FRAMEWORK

Figure Two (p. 171) represents a new conceptual framework for understanding violence and abuse against women with disabilities. The four cells are the same, although additional variables have been added, primarily to "predisposing factors" and "impacts." The cell examining "Abuse and Violence Against Women (With Disabilities)" remains the same, in its central location, for both Figure One (p. 73) and Figure Two (p. 171). The seven predisposing factors found in Figure One are repeated in Figure Two, although "dependency" in Figure Two also includes dependence on agencies and people, in addition to economic dependency. Additionally, there are three other predisposing factors which form part of Figure Two, including fear of loss of assistance or services, stereotypes and beliefs about disability, and disability-related risk factors. In terms of impacts, the three factors noted in Figure One are joined in Figure Two by an additional factor. This is "blaming disability" ("easy prey"). Finally, in terms of interventions, the framework is similar in Figures One and Two, with the alteration of social service system being sub-divided to include both abuse-related and disability-related social services.

Figure Two:

A Conceptual Framework for Understanding Violence Against Women with Disabilities



In addition to outlining the experiences of the women in this study, I will compare the experiences of women with disabilities in my study to those of women generally (as noted in the literature connected to Figure One). I will note points of similarity as well as departures, and will point out areas which might need further study.

6.3 ABUSE AND VIOLENCE AGAINST WOMEN WITH DISABILITIES

This section examines how the women came to define certain behaviours as abuse and the different types of abuse which were experienced. It also looks at who the perpetrators were in the various types of abuse.

6.3.1 COMING TO A DEFINITION OF ABUSE

In terms of actual definitions of abuse, it appears that women in the study utilized language and terminology introduced by us at the ILRC. The first step to inclusion in the interviews was the completion of the ILRC Abuse Survey. In this survey, standard descriptive definitions were given so that everyone would be utilizing the same categorizations for abuse experiences. This was a form of consciousness-raising for at least some of the women. For instance, Helios said, "There were some things I hadn't known were abuse until I saw them in the survey." Descriptions given by the women generally were consistent with the survey information.

<u>Knowing It Wasn't Right</u>

Women in the study were asked the question "How was it that you came to define this as abuse, assault, etc.?" Various

explanations were given by the women, but most said something along the lines of "just knowing it wasn't right" or that they just knew it was a particular type of abuse. For example, Atalanta said she "instinctively knew it was rape." Others said that they never did define it as abuse. Electryon was one of those who said that she didn't define it that way, that it was only when "I was told that by a psychologist, and even then I had difficulty calling it abuse." She continued, "When you grow up with a disability, you never know what things are due to; you often blame it on yourself and the disability--maybe people have said you're such a burden." It was difficult coming to terms with that, because it would mean defining one's whole life as being one of abuse.

"That Only Happens to Other People"

A number of women, such as Atthis and Thetis, said that it was much easier to see abuse in someone else's life. They believed that this was because you weren't so close to the situation, and therefore you could see that it wasn't right or deserved. They also said that particular types of abuse were easier to recognize and name than others. Medical treatments which were abusive were cited as easier to name. Other types of abuse, particularly emotional abuse noted by those with early onset disabilities, were harder to recognize. Verbal or emotional abuse connected to having a disability or to specific aspects of a particular disability, seemed very hard to come to grips with for the women. Several women echoed Antigone's statement that "I didn't realize til later that talking about my disability that way was abusive." Helios stated

that "it is hard to recognize when abuse is the norm and you have no one to talk to, or else everyone you know is disabled, and is experiencing the same thing." For these women, because of their life experiences, many just assumed that was how things should be if you had a disability.

"Aha"

Other reasons for defining instances as abuse included when it crossed some imaginary line. This could be seen as a "click" or "aha" experience, similar to that recognized during the consciousness raising of the women's movement. Suddenly, just as if a light switch were turned on, a number of people see what is happening. This recognition, and naming it, is the first step in dealing with abuse. One woman, Antigone, referred to this as when the straw broke the camel's back. One event finally was too much to continue seeing it as normal or coincidental. Demeter recalled that she only came to call what happened to her sexual harassment and sexual assault when it crossed the line of innuendo. Many things that are done as necessary parts of a personal care routine are very intimate, and it was only when there was no longer a shade of grey, when a physical event shocked her into reviewing other events, that she defined it as abuse. She said that she was lucky enough to have something "bad enough" happen to recognize this. Many women with disabilities, who were born with their disabilities or developed them at an early age, lack personal boundaries or knowledge of privacy, and this sometimes means that it takes more for the abuse to be recognized. Anyte added that it was difficult to sort things

out when family life, school life, medical life and growing up were all tied together.

Developing The Awareness

Several women talked about higher education and media/public awareness as being key factors in helping to raise awareness about what constitutes abuse. Athena, for example, talked about doing her own reading and research, because she just couldn't understand these things which kept happening in her life. Antigone at first thought it was common for her foster mom to belittle her, until later she gained an education which made her question things. Athena tried to find academic answers to what was happening, believing that trying to understand would be a way of easing the pain. She couldn't understand why people who were supposed to love you would behave that way. She also felt that many examples of emotional abuse related to disability were generational in a sense, and hoped that things would change in the future. She explained it in terms of "this was just the way things were for people with disabilities. There was no other way. No wonder they couldn't relate to how I was feeling."

Public education advertising or seminars were important identifiers for some of the women. Nausicaa and Ismene felt that general public information campaigns were more useful for women with later onset disability who could identify with non-disabled people to some degree. However, at the same time, many of these campaigns were directed toward recognizing physical abuse and sexual assault. Many of the incidents of abuse more directly

connected to a disability were still not recognized.

Artemis, who had a connection to the women's community prior to the onset of her disabilities, reiterated the importance of education and consciousness-raising. She was involved with a women's resource centre and read feminist magazines, and was able to carry that knowledge with her when she did develop her disabilities. Artemis was also an eager contributor to the women's peer support group that was run during the course of the project. She was able to bring in feminist teachings and discoveries, which other group members were hearing for the very first time.

Professional Influences

Counsellors and psychologists were also mentioned as good sources of learning. However, even then, some of the women, including Electryon, Thetis and Helios, noted that there still was no acknowledgement of some of the lack of respect and the maltreatment experienced in the form of emotional belittling. Counsellors often would not believe some of the stories, but more often would not believe the extent of the impact on the women's lives. For example, Helios talked about counsellors who felt that she really should be over "that" by now, despite the emotional toll the abuse took in the first years of her life. They talked about how it was important to start getting women with disabilities into counselling roles. This empathy and peer understanding was reflected in the significance and success of the women's peer support group on abuse.

Looking Back

Many of the women concurred that it was usually many years after the abuse that recognition and definition took place. Helios said that even doing the abuse survey was an important learning tool for many women with disabilities, especially those with early onset disability, who did not have access to comparisons growing up. Anyte echoed this sentiment saying she never really learned to ask "is this okay for this person to do this?" Normally this might not be such a big deal, but children with disabilities are taught to be compliant, passive and submissive in order to make caregiving easier for the caregivers and medical personnel.

Iambe said it was only in later years and looking back, talking to others, that she realized things could have been different. The reactions of others to her experiences was an identifier of abuse. She felt that if she had not developed her disability, some of the abuse would have happened, but not all of it. Hecuba, in counselling, discovered the same thing for herself. That is, some of it was probably due to being a woman, and some due to having a disability. Others, to this day, such as Caritas, still cannot call it abuse. Instead, they just define abuse in their lives by giving concrete examples, such as "when someone steals money from me; getting badgered and not letting up; not getting listened to; getting yelled at when I refused to give him money; having him yell at me, throw the phone on the floor, and hit the walls." Still others, such as Cyrene just call it unfortunate and unavoidable treatment.

Early Versus Late Onset Disabilities

Not surprisingly, those with late onset disability seemed to have a clearer conception of types of behaviour that could be seen as abuse. Those with early onset disability, particularly those experiencing verbal and emotional abuse, often blamed it on their disability, or saw it as the way things are, which felt more fatalistic. In other words, they normalized their experiences. Women with later onset disability were more likely to be able to separate some of what was related to the biological facts of their disability, although those who had not accepted their disability seemed to have more difficulty doing so.

Another striking difference between late and early onset disability was that several women with late onset disabilities talked more about men's position over women in society generally. Erinna, for example, said she "saw it [violence, abuse] as natural for men; and that women generally are owned, etc." These women also seemed to have maintained some relevance or connection to the women's community, which seemed to be an important factor in coming to define abusive instances as abuse. For example, they could hear a message about wife abuse, and still relate to it as women, whereas some of the women with early onset disabilities might not see themselves as women first. Due to early socialization, some women with disabilities were socialized to the role of "disabled," but not to see themselves as whole, functioning women. Therefore, they might not relate to messages designated for able-bodied women.

Now that <u>how</u> the definitions came about has been considered, it seems appropriate to look at what types of abuse were experienced, and who the perpetrators were.

6.3.2 TYPES OF ABUSE AND PERPETRATORS OF ABUSE

Chart Five lists the nature of abuse experienced by women with disabilities in this study. In this study, 16 women reported verbal/emotional/psychological abuse; 11 reported physical abuse; 8 told of childhood sexual abuse or assault; 14 experienced adult sexual abuse or assault; 4 discussed financial abuse or exploitation; and 6 reported neglect.

CHART FIVE - NATURE OF ABUSE EXPERIENCED

RESP. #	VERBAL/EMOTIONAL/ PSYCHOLOGICAL	PHYSICAL	CHILD SEXUAL	ADULT SEXUAL	FINANCIAL	NEGLECT	PROFESSIONAL/ CAREGIVER
1	*	*		*		*	*
2	*	*	*	*		*	*
3				*			
4	*			*			*
5	*		*	*			*
6			*	*			
7	*	*	*	*		*	*
8	*	*	*	*		*	*
9	*		*	*			*
10	*	*		*	*		*
11	*	*			*		
12	*		*	*		*	*
13	*	*		*			
14	*			*			*
15	*	*					*
16	*	*	*			*	
17	*	*		*	*		
18	*	*			*		
	16	11	8	14	4	6	11

Note: The totals in Chart Five include multiple experiences of abuse and therefore do not total to eighteen.

It is difficult to make overall generalizations about the types of abuse experienced due to the small sample size, but there are several occurrences which are noteworthy. For example, those with early onset disability in this study were more likely than those with late onset disability to have experienced childhood sexual abuse, adult sexual abuse, and neglect. They were also more likely to report having experienced abuse by a professional or caregiver. On the other hand, those with late onset disabilities were more likely to experience financial abuse. The experience of physical abuse was roughly equal for those of early and late onset disability.

Verbal/Emotional/Psychological Abuse

All but two of the women reported experiencing this type of abuse. Seven of the women had early onset disabilities and nine had late onset disabilities. One woman with an early onset disability, who did not say she experienced this type of abuse, did say she was given messages such as "You'll never account for anything!" and "You're just a cripple!", but did not label that as verbal abuse. This may be because for many of those with early onset disabilities, this type of language was commonplace from birth onward, and may therefore have been normalized.

This category included behaviour such as yelling, swearing, name-calling, put-downs, and threats. For example, Artemis talked about her father, who "interrogates me over everything; he screams, carries on, name calls." Amphitryon's common-law partner would "Call me a slut or other names like that, and threaten to strangle

me." Atthis recalled, "It seemed that all of them [male partners] would put me down. It was hard on the self-esteem and confidence." Erinna said that things done to people she loved were also emotionally abusive. An example of this was when "I would watch him [her father] beat up my mother and sister; he would hold a rifle to my mother's head. I lived in fear that he would come and get me next."

Some of these experiences were more clearly related to disability than others. Electryon, for example, recalled "I was called a lot of names like gimpy and batty because of how I got around or how I saw things." Athena said, "My relatives really had a negative attitude toward someone with a physical disability. They'd say all sorts of hurtful things, but they really thought their behaviour was acceptable." Degrading comments by others were commonplace for many of the women. Examples included "Why try, you'll never do it anyway" or "You're lucky to have me--no one else would want you." Helios recalled how her parents made her feel really bad about things over which she had no control. "Disability has been a real problem for my family and still is. They would verbally abuse me and make me feel bad for things like incontinence." Anyte said, "It felt hurtful to be given up [to foster care], but who wanted a disabled child?"

These messages reinforce the idea that disability is a bad state, and not desirable. However, in some instances of emotional abuse directed at a person's disability, the message is much more clearly negative. Women recalled being called names while growing

up, and being threatened due to their disabilities. Some examples will illustrate these negative messages: Athena said, "They made fun of my walking and talking. This made me really self-conscious." Helios remembers her mother's words in relation to her disability. "If God doesn't strike you down, I will" and "No one wants you. I wish you were dead." She also recalls her brother holding her at the top of the stairs and threatening her with being thrown down if she didn't "choose" to walk. Antigone recalled that "My caregivers couldn't deal with my physical condition without yelling and insults. I was continually told I was useless." She went on to say that "From birth until I was in my thirties, the emotional abuse happened at least weekly. This left a lot of emotional scars--[I] could never feel good." Ismene said, "I was told from early on that there would be those who would prey on us. That's why we should never go out." Amphitryon also related that she was told, "Everyone knows 'handicapped' people can't fight back." Those with early onset disabilities endured these disability-specific verbal assaults for a greater period of time, as it began at a young age, but was no less hurtful for those with late onset disabilities who were trying to adapt to having a new disability.

The perpetrators of verbal/emotional/psychological abuse included partners, parents, strangers, acquaintances, family, foster parents, the system, teachers, and psychiatrists or other professionals. For most of the women, abuse most often came from those they knew, often those in close relations. This also increases the impact of such abuse.

Physical Abuse

Physical abuse was described by eleven of the women (four with early onset and seven with late onset disabilities). This included a range of actions, with and without weapons or objects being involved. Women described being spit at, slapped, having hair pulled, being hit, punched, pinched, kicked, held down, beaten with a stick, having things thrown at them, being strangled, stabbed, and shot at. A number of examples will illustrate this type of abuse. Amphitryon recalled that "Not only did I have things thrown at me, but he would beat me, or throw cold water on me while I was sleeping." While growing up, Erinna was subjected to "a lot of hitting and kicking; I was thrown downstairs, and also thrown outside in winter with no clothes on." As an adult, Erinna was "Slapped and hit a lot. He would throw things, and he also made me work the street." Some of the abuse was put forth as discipline, such as the beatings with a belt which Helios endured.

Some of the physical abuse was seen as unique to women with disabilities. This included situations where the abuse involved someone shaking or kicking a wheelchair. Antigone also said that "By taking my wheelchair away, they might as well have locked me in chains--I couldn't move without it." Leaving someone in soiled clothes or beds, such as was experienced by Helios and Demeter, was also seen as physical abuse. Another unique example was offered by Helios. "They [my parents] would dangerously restrict my fluid intake so that they wouldn't have to take me to the bathroom." Her health was put in jeopardy at times out of this need for caregiver

convenience.

The perpetrators of physical abuse for women with early onset disabilities included: parents for three of the women, and the whole foster family for the other woman. For those with late onset disabilities, the abuse was mostly done by partners/husbands, but also by a parent and a stranger.

Childhood Sexual Abuse

Eight women spoke of childhood sexual abuse. This included six women with early onset disabilities and two with late onset. It included a range of behaviours, from flashing to touching and intercourse, at a variety of ages. Antigone said, "My father started to sexually abuse me when I was a little kid...maybe three years old." Anyte recalled, "They started talking and putting their hands all over me, touching me." Helios was sexually abused by both parents, including being penetrated by objects. Hecuba also talked about the incest she experienced at the hands of her father. A number of women said that it was hard to remember a lot of the experiences, and they were thankful for that.

The perpetrators of childhood sexual abuse for those with early onset disabilities included parents (usually fathers, but not always), family friends, and a partially known stranger. The abusers for those with late onset disabilities included a member of the extended family (an uncle) and a sister's boyfriend.

Adult Sexual Assault

Fourteen women revealed having experienced sexual assaults as adults; this included all nine women with early onset and five

women with late onset disabilities. Types of experiences included in this category were: sexual harassment and "obscene behaviour" (in-person and by phone), flashing, inappropriate touch, rape, and other forms of coercive sex. For example, Nausicaa described two occasions. "One guy threatened to break my legs if I didn't have sex with him. Another had sex with me in return for helping with my groceries. I agreed to have sex with them, but it seems a bit 'coercive.'" Demeter reported that her orderly "Put his head between my legs and started on me...while doing my personal care." Amphitryon described her horror when her boyfriend came to the hospital after her accident and tried to rape her. "It was terrible! I couldn't move or call out." Electryon talked about the frustration of not being able to resist. "What can you do? He just pulled me out of my chair and took all my clothes off."

The perpetrators for those with early onset disabilities were parents, drivers, caregivers, acquaintances, dates, and strangers. For those with late onset disabilities, the perpetrators included strangers, partners, professionals, neighbours, and dates.

Financial Abuse or Exploitation

Four women, all with late onset disabilities, reported financial abuse or exploitation. Two cases involved partners controlling the money and using it for their own gain. For example, Amphitryon said, "He would take advantage of me financially, by stealing from me. He'd enjoy the money and I'd just barely scrape by." Erinna was forced to work the streets so that her partner could take the profits. Caritas found that her son constantly badgered her

for money. When she wouldn't give it to him, he just stole it. Finally, Cyrene spoke more of the constant fear that people around her would steal her money. "Since that one time, I am always living in fear, knowing they can take my money and things at any time."

Those exploiting the women included partners, people in the building and on the streets, and a son.

Neglect

A total of six women said they experienced neglect. This included four women with early onset disabilities and two with late onset disabilities. For all of them, the neglect began at an early age. Both of the women with late onset disabilities, however, felt the neglect by parents and family worsened with the onset of their disabilities, or that it had a greater impact on them. The women provided similar accounts of the emotional and physical neglect they experienced at the hands of parents (four women experienced this) and family members (two women described this). Electryon was often left "trapped in my room for a day at a time. My parents never showed any emotion or feeling for me." Helios felt that sometimes even their basic physical needs were not taken care of. "I think we were malnourished to make it easier to handle us, especially for physical care."

Actually, in reflecting upon all eighteen of the women's accounts, particularly those with early onset disabilities, it would appear that all may have been subject to neglect of one sort or another. However, neglect is one of those nebulous categories. If you do not believe you have the right to love, care and attention, as

well as the basic necessities of life, you probably would not recognize neglect.

Professional or Caregiver Abuse

Since a number of women specifically singled it out, a bit more attention should be focused on abuse that is perpetrated by caregivers or service providers. Their involvement in the lives of the women was due to the women having disabilities. This included examples of sexual assault, childhood sexual abuse, emotional abuse, and physical abuse. Other instances included threats of the loss of assistance or services, or the refusal to provide the necessary assistance or services. Sometimes this was done in a punishing way. Demeter, for example, was told that if she did not stop "rocking the boat," all orderly service would be discontinued. This gave her the choice of staying in bed all day or allowing the abusive orderly back in. Helios noted that, "It was sometimes hard to distinguish between touch for cleaning and hygiene, and abusive touch." She said that she had experienced inappropriate touch a number of times during her personal care routines. It is also important to consider that women with disabilities in this study reported that due to physical or emotional dependence on these people or services, along with a lack of options, power and control were skewed in favour of the caregiver or service provider.

Other things cited as abuse were more systemic. This included highly restricted opportunities for independence and decision-making. A number of women talked about having over-protective parents. This, they said, could also have been referred to as

depriving people of experiences. Anyte reported "They didn't think I could handle myself with other kids." Hecuba said that she was really isolated as a teen, but she isolated herself. She had become very uncertain and afraid of her ability to interact with others; she felt different. This was after her parents originally kept her from doing things outside the home in order to "protect her." Electryon also said, "I was never given a chance to learn, take risks." Electryon and Anyte were most vocal in saying that they believed such behaviour <u>was</u> abusive and was the direct result of having a disability. Anyte also felt that parents giving up their children to foster or institutional care, simply because they had disabilities--even if a common practice--was abusive. The reason for this was the "emotional impact of the message--we don't want or value you." She felt that this was the ultimate in emotional abuse.

In sum, these women experienced the same types of abuse as non-disabled women do, although there were some unique features related to having disabilities. As noted, there are a number of circumstances connected to disability that they viewed as abusive. They may also be more subject to abuse from caregivers and professionals, as well as more vulnerable to threats of, for example, loss of services. It appears that the perpetrators are much the same, aside from the increased contact with caregivers and professionals. I should note that, due to the nature of the questions asked in the interviews, we have no information on the attributes of the perpetrators.

6.4 PREDISPOSING FACTORS

Predisposing factors refer to those aspects of the experiences of women with disabilities which put them at risk of abuse or keep them from escaping or leaving abusive situations or from otherwise receiving assistance in dealing with such situations. In addition to the seven predisposing factors noted in the general literature on abuse and violence against women (Figure One, p. 73), I have added three factors. Therefore, the predisposing factors in Figure Two (p. 171) include: family of origin, dependency, the love bond, keeping the family together, isolation, fear of harm, lack of options, fear of loss of assistance or services, stereotypes and beliefs about disability, and other disability-related risk factors.

6.4.1 FAMILY OF ORIGIN

Questions were not really asked about family of origin, except as related to childhood experiences of abuse. A number of women did volunteer information about their early years, particularly as they were relating accounts of what it was like to grow up with a disability. The detail and information about specific aspects of their family, such as culture and religion, male dominance and patriarchal structure, and women's role in the family, is therefore quite limited. For the women in this study, the family of origin factor will be focussed on the presence of abuse and violence in the family of origin. Future research should ask more specifically about these factors, including gathering information about culture, religion, etc., as well as information about the perpetrator's family of origin if possible.

Growing Up

Seven of the women with early onset disabilities described growing up in abusive or violent environments. Much of this was verbal, emotional or psychological, but also included physical and sexual abuse and neglect.

A number of the women, including Antigone, Helios, Electryon, and Anyte, described abuse and violence in which they were not the only victims in the family. Siblings, the other parent, and other foster children were also abused. For these women, the abuse was not just because they had disabilities, since non-disabled individuals were also abused. Anyte summed it up by saying, "My natural family was very dysfunctional all around. So were the foster homes I was in." Antigone said "All of the abuse around me all of the time made me feel bad most of the time, but I didn't really realize it should be any different than that." Electryon noted that "There was always a lot of drinking and swearing and fighting. Everyone got hurt I guess." In fact, Electryon's disability may have spared her experiencing some of the abuse, as her medical needs necessitated hospitalizations which removed her from the family home at times. Electryon's brother, who remained in the home, eventually killed himself, which she felt was the result of the abusive environment.

For the other three women with early onset disabilities, who were the only victims in the family of origin, they were led to believe that the abuse and violence was the result of their disabilities. Hecuba, for example, revealed that "The emotional

abuse and neglect by my parents was because I had a disability. So was the advantage taken of me by siblings." Antigone raised the question: "I wonder if they set us up to have a victim mentality?" This is a good question, considering all of the women with early onset disabilities were later sexually abused or assaulted as adults.

Five of the women with late onset disabilities described abusive or violent homes growing up. This included Artemis, Thetis, Atthis, Iambe, and Erinna. The other four really did not talk about their families growing up. The five women described a combination of verbal, emotional, physical and sexual abuse. They said that their families were generally abusive and dangerous. For example, Artemis said that both parents would "Scream, yell, call names. They would hit me, leaving black eyes, welts, and bruises." None of the women discussed whether siblings were also abused, but two did describe siblings as being abusive.

Current Family Dynamics

Finally, a number of the women talked about the behaviour of their families in the present. Approximately half of them related that their families were still abusive, demeaning or cruel. Much of this was emotional abuse or neglect, but in one case there was also the threat of ongoing physical abuse. Electryon stated "Maybe I don't have the constant physical fear I had while growing up, but my family continues to hurt me in other ways. What they say and call me, how they make me feel, and how they're never there for me, is almost worse." Helios said, "My family is still really harmful. I don't think I can ever have a 'normal' family." Referring to her

partner, Atthis said she believed that he felt justified in his abusive behaviour, as she could no longer fill her responsibilities in the family by being a "good" wife. Many of the women described their families as their primary source of abuse and put-downs.

Families of origin for the women in this study tended to be abusive in nature, particularly in terms of verbal and emotional abuse, but also other types of abuse. As noted in the general literature reviewed previously, abuse in the family of origin is often connected to future patterns of abuse. The women in the study in some instances become "easier prey" because they may normalize a greater degree of abuse, as they have become accustomed to this. Also, some may find it harder to discover a "normal" life. It is hard to know what, if anything, was different for the women who did not talk about abusive families of origin. The data is not available from these women, as I did not ask specifically about this, and they did not offer information on their families. Therefore, no conclusions can be drawn.

6.4.2 DEPENDENCY

For women with disabilities in the study, there are three aspects of dependency that were highlighted: financial or economic dependency, dependency on agencies of the state, and dependency on people.

Economic Dependency

Only three of the eighteen women were able to see themselves as financially independent. This included only one woman in the study who was working, on a part-time basis. The remainder of the

women were in dependent positions. Several of the women felt they were financially dependent on their husbands or partners, even in the example of one woman whose partner stole from her and exploited her financially. As another example, Iambe said, "My husband did lots to control me. He controlled the purse strings and I had to put up with things because of that." The rest of the women, rather than being dependent on husbands, were dependent on social assistance or meagre disability pensions. Overall, most of the women saw themselves as quite poor, and poverty itself can be detrimental to self-esteem. A number of the women noted that both welfare and the insufficient pensions serve to "keep you down." Themes noted were that you could never get ahead; relying on these sources of support felt degrading; and someone else was in charge of your life. Artemis, for example, noted that, "You can't even decide where you want to live or when you want to move. Welfare calls the shots." One woman, Nausicaa, said, "Welfare itself is abusive. The workers treat you terribly."

Economic dependence, as for women generally, serves to keep women with disabilities from being able to feel independent, and may practically keep them from leaving unhealthy or abusive situations. This, in combination with the low self-esteem reported by some of the women as connected to poverty, keeps many women from reacting to, or leaving, abusive situations.

Dependency on Agencies

Another source of dependency for many of the women was having to rely on state agencies such as home care or mental health

services. Demeter was most vocal about the home care system, although a number of other women said similar things. Demeter noted that "Home care is a very controlling system. You have no rights about who comes into your home ... When you question anything about your service, you are threatened that you might not receive any service at all." She also said that they know you can't get along without the service, and take advantage of that fact to "keep you in line."

The mental health system was also mentioned as being quite controlling and fostering dependence. Nausicaa said, "I have had so many mental health workers try and run my life." Thetis also reported that "It was people in the mental health system that were most discouraging--to both doing something about the abuse and to trying to better myself." Helios talked about the dependence by saying, "They make it so you feel like you can't trust yourself. You are supposed to be dependent on them, although then they tell you that you should be more independent. The messages get all mixed up."

Dependency on agencies was seen as increasing the risk of abuse in a number of ways. First, it increased the number of people who came in contact with the women--a number of whom might potentially be abusers. Second, because the women were dependent on their services, they would often tolerate a great deal rather than risk losing the services. Finally, the dependence may have kept some of them in a more child-like and vulnerable position, by increasing their own perceived lack of independence.

Dependency on People

Finally, many of the women described being dependent on various people for a variety of reasons, including caregiving, support, to avoid being totally alone, and because they come to believe they cannot manage on their own. Many of these people were in some sort of continuing relationship with the women despite the abusive nature of some of those relationships, due to the dependence the women felt for these people. These individuals consisted of both family and non-family.

Much of this dependency was necessitated due to the disabilities of the women. For example, some of the women with physical disabilities need someone for assistance in daily tasks. Atthis, for example, stayed with her abusive husband for some time simply because he helped her to get dressed as well as to get in and out of bed. Amphitryon also said, "I felt that I should put up with some of how he treated me because he helped me to do things like eat and get into bed." Several of the women noted that this physical dependence also left a person feeling more vulnerable to abuse. Antigone, for example, said, "When you can't even move on your own, you really feel vulnerable."

Women with disabilities are often dependent on the abuser, in the case of a caregiver, for physical care which they require in order to operate on a basic level. The provision of physical care may be viewed as very difficult and draining. Therefore, in the case of an abusive care provider, who may go as far as killing the individual in his/her care (as noted earlier in the Latimer case), there may be a

great deal of sympathy for the perpetrator, who may present his/her actions as attempting to end suffering. The picture painted is that to live with a disability is to live a life of suffering, even though a number of women in the study categorically said it was not so.

A word of caution is in order. Not every person in the public realm will believe the abuser and be sympathetic. However, there is likely to be both a caring and an uncaring public. The prevalence of myths and stereotypes make it all too easy for people who want to ignore or deny such abuse to create excuses or rationalizations.

In circumstances of pervasive stereotypes and myths, it facilitates abusers to rationalize and deny their behaviour and present it as "normal;" it makes it easier for abusers to present themselves as the victim. This is what happens when powerful people abuse less powerful people. Since people with disabilities are seen as burdens and highly dependent on others, even abusive caregivers may be seen by some as charitable martyrs, even when abuse happens. This same dynamic of rationalization happens for women generally. In these instances, abusers use patriarchal myths and stereotypes regarding men's and women's roles, as well as parent and child myths, to rationalize their behaviours. However, the devaluation of people with disabilities does increase the pervasiveness of the dynamic. People relate to what they imagine must be great frustration and personal selflessness. This occurs because many people in the public cannot imagine living with a disability, and therefore assume that no one would want to live in such a circumstance.

It is frightening to discover how many of the women endured abuse of various sorts to keep from being left alone. Caritas stated, "What things keep me from breaking this off? I don't know. I guess I have this fear that I'll be totally alone." Helios said, "It's funny how much you'll put up with because you believe that you need them or that it's better than being alone." This feeling was strengthened in that the women really believed that otherwise they would be alone. They assumed, or were led to believe, that no one else would want them.

Another belief of the women was that they would be unable to care for their affairs properly. Anyte, although young, felt that care providers "never felt I could do it. They always underestimated me." Caritas also came to believe that she was unable to manage her affairs based on what was happening to her. "I don't know--maybe they're right; maybe I just can't handle [my accounts]." Although some women may in fact be unable to manage their affairs, it is usually assumed that all of the women with disabilities lack this ability. For someone to not take advantage of these shortcomings, as in financial abuse, almost seems foolish. Amphitryon said, "Who could pass up on such an opportunity?" The other thing this does is justify the control by others of the lives of women with disabilities. Helios, for example, said that her family was very controlling because someone had to take responsibility. Meanwhile, she felt that "No one ever gave me a chance to really take risks and try to do it myself. Not on things that really mattered to me."

Finally, a number of the women articulated a generalized

feeling of dependency. Helios said "I never had a chance to develop a good sense of who I am...When the abuse happened, it shattered what was left." She said she developed a lot of other fears, such as a fear of abandonment, and this led her to be even more frightened and dependent on others. Ismene described this as "learned helplessness." She felt she was unable to do things for herself and that others would take advantage of her. People with disabilities are taught to see themselves as the cause of negative events, while others are responsible for positive events. Additionally, it meant that she tolerated even more abusive behaviour because it was "better than nothing; better than no one."

Not only do these dependencies serve to keep women subservient, but they also keep women silent. This puts and keeps them in potentially dangerous situations. The dependencies described by the women with disabilities in my study are not all that different to women generally (as found in Figure One, p. 73), although some of the women in this study talked about additional sources of dependency versus the economic dependency typically focused on in the non-disabled women's literature.

6.4.3 THE LOVE BOND

The love bond identified in the literature was also a factor for women with disabilities. For several of the women with late onset disabilities, this bond was with the male partners in their lives. An example of this was Amphitryon, who said, "We were together for five years even with the abuse. I thought he loved me--and, he did help me out with things around the house." One other woman with

late onset disabilities also mentioned the love bond, but for her it seemed to involve more of a bond of duty. Iambe said that "He was my husband. What choice did I have but to stand by him? I don't know whether or not it was love." It is difficult to recognize love if you have never known love, which was the situation described by Iambe.

The love bond also involves parents, family members, and children. This was the case for a number of women with both early and late onset disabilities. Perhaps related to low self-esteem, the women expressed sentiments of love for these people even though abuse occurred at their hands. Helios, as an example, said, "I knew that what was happening was wrong, but she was my mother." Therefore, she felt some connection or obligation to this blood tie. It also reveals a desire to have a "normal" parental relationship, at all costs. Antigone reported that "They were the only family I had." This kept her from escaping the abuse, as she was afraid to lose whatever family she did have. Caritas tolerated the abuse from her son out of a combined fear of being alone and because he was her son. "What do you do when it's your son? You can't lock him up in jail--it's your flesh and blood."

Artemis, speaking of the situation more generally for women with disabilities, said: "Women with disabilities feel they are lucky to have anyone to love or to love them, so even if there's a price tag involved, it doesn't matter. Sometimes the price is abuse." Much as many able-bodied women have been socialized to believe they must have a husband as a source of status and self-esteem, many women

with disabilities have been socialized to fear being alone and to do whatever they have to in order to have a "normal" life. This includes having a partner. It is as if many women with disabilities are desperate for love and affection, to the point that they are grateful for any attention at all. It is as if these women are saying "It's better than nothing."

There is also some degree of fatalism which is revealed. This fatalistic view may add to the psychological and social baggage which has many of the women with disabilities see abuse as inevitable. This fatalism may be linked to the sequential abuse experienced by some of the women, such as Amphitryon and Electryon.

Several of the women recalled their perpetrators justifying sexual assault by saying things like "I thought you'd like it" or "You should be lucky for the attention." The assumption was that no one would find them attractive enough to want to be with them. This suggests a perception that women with disabilities as a group are not desirable. Antigone said, "Because no one wants me, I'm supposed to put up with all sorts of stuff. It's not fair. It's like you should be lucky to have any attention." Helios revealed "All I ever wanted was my mother's love...If you're a person with low self-esteem, you're so grateful and you'll take anything--you may not even see it as abusive."

For some of the women, the love bond, be it for partners, parents, families, or children, was a salient feature in keeping women with disabilities from recognizing and/or leaving abusive

situations. A pervasive theme is that "anything is better than nothing." The women who commented in this regard seemed to resign themselves to the perception that "this is the best I can do because of who I am." For the women in this study, an important feature in defining "who I am" is the presence of disability. Due to internalized negative perceptions of disability, as well as external ones, these women felt that this was the best they could do.

Similar to women generally, some women with disabilities do whatever they can to protect their abuser from outside intervention. Part of this is due to fear of further harm or shame, but several women did it because "I loved him in spite of the abuse."

Again, future research should ask about the love bond. This brief presentation is limited to those women who offered information about the love bond in the course of their stories. If we had asked more specifically, others may have talked about this factor. As well, there may have been greater depth and insight shown by some of the women.

6.4.4 KEEPING THE FAMILY TOGETHER

There are some points of difference in this area when comparing the literature for able-bodied women and the experiences of women with disabilities in my study. The major source of difference was the fact that few of these women with disabilities had children. Women with disabilities are actively encouraged not to have children. In some cases, women with disabilities are encouraged to terminate pregnancies through abortion or to avoid them through sterilization. Because people with disabilities are

believed to be asexual, women with disabilities are often cut off from the opportunities to have children of their own. Also, even when women with disabilities have children, it is assumed that their disabilities make them unfit to care for and raise their children. Atthis, for example, said, "When I needed a wheelchair [became disabled], he [my husband] kicked me out and kept the kids...He said I wasn't good for anything anyway and I certainly couldn't be a mother in my state." Artemis also said she feared the loss of her children with the onset of her disability. In some respects, then, the fear of loss of children is more related to disability than to abuse for the women in this study.

This is a distinct difference to the general literature, where the children are often used as pawns, and are an important part of many women's decisions to stay in abusive relationships. As only two women spoke of fear of loss of children due to acquiring a disability, it is hard to know whether or not this is a common occurrence for women with disabilities, but based on the literature on parenting (Ridington, 1989c), it would seem likely.

None of the women in my study spoke about fear of loss of children in relation to abuse. However, had we asked specifically about this, there may have been some women who had experienced this. Also, none of the women with early onset disabilities in my study had children. Of those with late onset disabilities, five had children (prior to the onset of their disabilities). Three of the five had their partner leave and take the children shortly after the onset of disability, saying they were unfit parents due to their

disabilities. The remaining two did not speak about their children. This would be a point for future research.

Keeping the family together is another theme that was present for the women, but also in a different way than presented in the general abuse literature. For many of the women with disabilities in this study, they received the message that their disabilities made it difficult for their families, thereby making it hard for the family to stay together. Helios was told that her family had to give up a lot of things due to her disability, including being able to move and take on better opportunities. Electryon also recalled being told that her father's binge drinking and related violence was her fault, because of her disability. A number of the women came to believe that they were responsible for family functioning (or lack of it), and out of guilt, they would do nothing further to endanger the family. Therefore, much abuse would be tolerated, since reporting familial abuse would simply cause further "trouble."

This higher tolerance was an important factor in putting some of these women with disabilities at risk for abuse, and could also lead to greater reluctance in leaving abusive situations. This regard for family functioning is noted in the literature to be generally high among women, but with the added perception that "having a disability means being an extra burden," some women with disabilities may feel additional responsibility and guilt. This may get translated into further inaction.

6.4.5 ISOLATION

Isolation was the most consistently cited factor regarding abuse for the women in this study. The women discussed being alone, both in terms of physical separation and also psychological separation.

Many of the women in my study felt that having a disability and theoretically being "highly protected" really meant being isolated and segregated. Anyte, Hecuba, Helios, Electryon and Antigone all felt they had been isolated growing up and continuing even into adulthood. Antigone said that the only time she got out was to go to school, and even many of the schools were separate, but not necessarily safe. She said that this "limits your opportunities to tell people about what's going on." Electryon felt that because she was so alone, she did not even know to call what was happening "abuse." Helios also talked about the isolation. She said that "being alone, you don't know that this [abuse] isn't normal or okay."

Not only did this restrict interactions, but it also meant fewer opportunities to get together with others to "compare notes." Therefore, the women were left believing that this "was normal--the way it was for everyone" (Helios). There was no way of knowing that abuse and neglect were not the norm. A second aspect of this isolation is the lack of opportunity to develop a support network and friends. This, for some people, was accompanied by an even higher desire to meet people and spend time with them, leading perhaps to even less discretion in terms of those with whom they had contact. One woman described having had "a desperate attempt to meet

people because I felt so alone."

Two of the women spoke of a physical separation from their families and communities at an early age, which was necessitated by their need for medical services not provided in northern communities. Anyte and Electryon both had to go to Winnipeg in order to receive services. This meant even less time spent with their families and their native culture. Electryon said "I hardly knew my family. What kind of influence can that be?" Anyte talked more about how this separation meant that she lived her early years in a number of foster homes. These foster homes were abusive and neglectful. This separation from family was mentioned by some of the other women, who talked about the time they spent in hospital, at special schools, or in rehabilitation. Anyte said, "I was so desperate for someone to love me, that I likely opened myself up to further risky situations."

Isolation and segregation were also the reality for some of the women with later onset disabilities. Cyrene, for example, said she "never felt more alone and less able to get out" since becoming disabled. Nausicaa told of being limited, in her social interactions, to those most likely to take advantage of her. "Because I'm on welfare, I can't afford to get away from these people, these areas; because of poverty, I can't get away from these people, many of whom are my abusers." Iambe also said her husband and her disability, combined with rural surroundings, did much to "control and isolate." She said that "others cannot or won't believe me -- even now."

The isolation may be complicated by related factors such as poverty and lack of accessibility. Isolation may also be increased due to abuse. For example, Iambe spoke of her husband's work to isolate her as part of the abuse she experienced. "I had strict orders not to go anywhere without him. I was out in the middle of nowhere anyway." For others, this isolation as a result of abuse was more internal. Amphitryon, for example, said, "I just felt more alone. Even though people were right there, they might as well have been miles away because I couldn't reach out." Whatever its forms, isolation adds to the vulnerability of these women.

Isolation is also a factor for women without disabilities, as found in the literature. However, it seems that a key difference here was that for the most part, many of the women in my study saw a distinct link between disability and isolation. They felt that this additional isolation was connected to even greater vulnerability to, or inability to escape from, abuse.

6.4.6 FEAR OF HARM

For women generally, as noted in the literature, fear included fear of personal harm, fear for the safety of others, and fear for the safety of the abusers. Women in this study only mentioned information related to the first two. Due to having not asked about this directly, I am uncertain as to whether this is a true difference, or one due to limitations in my data. Future research could look at this factor and shed light on the subject.

In terms of fear of personal harm, women tried to avoid abuse and harm through "good" behaviour, and in many cases did not report

abuse out of fear of retaliation and further harm. Iambe said, "For years I tried to be the 'good' wife, despite my arthritis. I thought if I did, he'd leave me alone."

A number of the women felt an increased risk of harm due to their disabilities. Athena believed that "When it's harder to fight back and your bones are brittle, you really worry about getting hurt." Artemis also said, "I know it would be easier to hurt me because of my disability. Things are a lot more fragile." Antigone revealed that, "I had to deny that my parents hit me because I was afraid--both that I'd really get it, and also that no one would believe a disabled kid." Hecuba also said, "I've a pretty fragile condition. It wouldn't take much for permanent brain damage." At one point, Helios had to consider a more indirect harm. Her mother threatened to leave her if she told about the abuse. Helios feared that she would starve to death because she wouldn't be able to get out or call anyone else for assistance. Thetis feared that she would be "sent back to the mental institution if I told [about the rape and the abuse by her psychiatrist]."

A number of the women spoke about fearing for the safety of others. This primarily involved siblings and children. Electryon worried that her father would also harm her sisters--which he did. She said, "Sometimes I worried more for them than for me." Anyte and Helios also talked about fearing for their sisters and brothers. Atthis and Iambe worried about their children. For example, Iambe said, "I was overprotective of the kids because I didn't want the same thing to happen to them."

6.4.7 LACK OF OPTIONS

Many of the women felt they lacked options in dealing with the abuse. They felt that there was no one they could call and nowhere they could go. Antigone said, "There was nowhere to go...and no one I could trust to tell." She "figured that no one could, or would, help because of the disability." This skepticism was due to two related beliefs. The first is the belief that resources are not accessible to women with a variety of disabilities. None of the women in this study knew of accessible community resources, except perhaps for the hospitals, which were not always viewed as the answer.

The second belief which limits options is that there is a perceived lack of understanding of the unique needs of women with disabilities. Helios, for example, said, "There's no way they would want to accommodate my personal care needs. They wouldn't know how." Atthis, who has a speech impairment which causes her to slur her words, related that people in the community, including the police, "think I'm just a drunk making crank phone calls." Thetis said that "I tried to get counselling once, but they were afraid because I had been institutionalized."

Several women made statements to the effect of "People just don't understand what it's like to grow up with or live with a disability." Therefore, they don't trust that people will be sensitive to their needs and issues. Hecuba felt that "We need more counsellors who have disabilities. They would understand." All of these things limit their choices of what they can or will access.

Lack of options means that many women with disabilities

cannot, or feel they will not, gain access to responsive assistance regarding experiences of abuse. This is a similar situation to women generally, who tend to tolerate a great deal of abuse because they are unaware of options for themselves. However, there is the added belief that options are even more limited due to disability-related factors. Although my data does not reveal the answer, I wonder if the increased hesitancy or lack of response due to disability is similar to that experienced by immigrant women or aboriginal women who often report feeling uncomfortable with services set up for and run primarily by white, middle-class women. For the women with disabilities in my study who talked about lack of options, this is a very important factor in either deciding to not leave an abusive situation, or in not even seeing that there is a decision to be made.

6.4.8 FEAR OF LOSS OF ASSISTANCE/SERVICES

The fear of loss of assistance and services was a significant factor preventing a number of the women in my study from leaving or reporting an abusive situation. In more than half the cases, anything was viewed as better than nothing. This included putting up with abuse.

The most frequently mentioned assistance/service was personal care services. For women in this study, these services are provided by professional government services, partners, or parents. Demeter was most outspoken about government-provided services. When she complained about an orderly sexually assaulting her, she was met by resistance from management of the service. They

threatened to take her service away. She was told, "You might find yourself without any service if you keep this up." Since there was no other affordable service at the time, this made her tread more softly, rather than risk "Laying in bed all day."

Amphitryon spoke about how she put up with abuse from her male partners because they helped her with personal care and daily assistance. "They helped me eat, get dressed, get up, get into bed. I wouldn't have been able to do much without them." This made the decision to break up all the more difficult.

Finally, three women talked about relying on their parents for personal care and assistance with daily living, and how they feared losing that help. All children are somewhat dependent on their parents for survival, but Electryon said, "When you're disabled, you can't even get up or out of the house yourself." Helios also said, "You're in a no-win situation. What they do to you is abusive, but you need them, even as you get older." Despite the irony, Antigone said that "My worst fear was being sent away to live in a foster home." The irony was that perhaps the foster home would have provided more safety. Rather than lose this source of assistance, all of these women tolerated abuse.

Nausicaa and Thetis feared the loss of service from their psychiatrists. They said their psychiatrists had told each of them to find another psychiatrist if they insisted on pursuing "this issue" [abuse and sexual assault]. Thetis said, "They may not be very good, but it's hard to find psychiatrists who will take you on, and I need my meds."

Athena believed that if she reported her sexual assault by a specialized transit driver, she would not be able to use the service in the future. "It's not that they would cut you off--actually they could--but they have ways of making you feel unsafe. Other drivers will make it hard on you too." When women rely on a specialized accessible service, and there aren't other options, decisions become very difficult to make.

As can be seen, fear of losing these and other services keeps women with disabilities in a vulnerable, dependent position. This fear is fed by the "better than nothing" perception, held by a number of the women, which was discussed earlier. Fear, based in reality, forces many women with disabilities to remain in situations which are abusive or which have the balance of power resting inordinately with the service provider, which may also limit their perceived choices. In order for this to change, there needs to be a range of options and services available to the women, so that choice can be exercised. Since these women require these services for their physical or mental well-being, this is a point of departure to the case of women generally as cited earlier in the literature.

6.4.9 STEREOTYPES AND BELIEFS ABOUT DISABILITY

There were a number of beliefs about disability that were expressed by the women in the study. These were shared in the course of the interviews, with almost all of the women holding at least one of these beliefs, but not all. Some are related to the beliefs and stereotypes considered in the Chapter One literature review. These beliefs make women with disabilities vulnerable to

abuse and make it more difficult to get help to escape the abuse. These beliefs reflect the devaluation of women with disabilities which helps put them at risk of abuse. The devaluation in many cases also leads to less sanctioning of perpetrators.

One stereotypical belief is that people with disabilities are less than or not human. Several of the women with early onset disabilities in particular expressed that they felt "people cared about pets more than us; they seemed more valuable." Anyte said that a number of times, she recalled "being called an 'It'." This clearly demonstrates that some people do not see people with disabilities as human. Electryon said that, "We weren't even expected to get an education because we were seen as less."

Other examples of this stereotyping included the view that life for people with disabilities is not worth living or that they would be better off dead. These sentiments were wished upon Electryon and Helios, for example. In one case, a family friend was overheard talking to Electryon's parents. In the other, Helios was told this directly by her mother who, she felt if given the chance, would gladly have ended her life like an unwanted kitten.

An outgrowth of "less than human" thinking is that people with disabilities are easily objectified because they are somehow not human. Due to the power of language and imagery, a recasting of experience is created. People move from treating something "as if it were" to "it is." Amphitryon, talking about personal care, reported that "In personal care, I was sometimes treated like a sack of potatoes. I'd get shuffled whenever it was convenient. I don't think

they cared whether I had feelings." People act towards those with disabilities as if they aren't human, and then treat them as not human. Being seen and treated as an object is in itself a form of abuse, but can also lead to or allow other forms of dehumanizing or abusive treatments to occur. Ismene said, "I felt like they could do whatever they wanted because they didn't see that I breathed and had feelings." Antigone stated "It's emotional abuse to be treated as a lesser being."

Another stereotypical belief was that women with disabilities, although fully adults, were childlike and should not be making independent decisions. Thetis and Nausicaa, for example, talked about doctors who did not deem it necessary to obtain informed consent about procedures or treatments, because "as [a] disabled [person], they assumed I could not really make a choice. If they asked anyone, it was my parents, even though I was almost 30 years old at the time."

Electryon said that this pattern was set up for her in childhood. "Because of my disability, my abilities were minimized, overpowered. I was never given a chance to learn or take risks." This, she said, makes it harder to make decisions as an adult, because without practice, "you are more likely to look to someone else to make those decisions." People with disabilities are not given options to make the choices in their lives. People with disabilities then do not trust themselves to take the risks of decision-making. People with disabilities are often infantilized, patronized, and not taken very seriously.

Antigone also spoke of being overprotected while growing up. She recalled that "even on my highschool graduation, I wasn't allowed to go out with friends." Anyte, in a similar fashion, said it was overprotection in a "twisted sort of way. They said it was for your own good -- to protect you -- but it kept you from growing. It isolated you in the abuse." The women felt that in some ways, the limiting of experiences kept them in a more childlike -- dependent and vulnerable -- state. This was then used against them when they did try to assert any choice or independence. They were told that they had no experience making decisions on their own. Related to this is that people with disabilities are expected to trust others rather than asserting themselves.

The women in this study believed that members of the public generally assume that all people with disabilities are helpless and particularly hopeless. On one occasion, I was discussing the project with a friend, who felt very strongly that all women with disabilities were helpless and vulnerable. This, for her, was unquestionable. When we began talking about individual examples, she began to realize that what she meant to say was some women, in different ways, and at different times. All women with disabilities are not the same, and do not all have the same limitations or the same strengths. The perception that women with disabilities were all easy prey was also held by the women in the study. It was directly referred to by a number of the women, including Electryon, Amphitryon, Antigone, and Cyrene.

The flip side of this coin is that due to perceived vulnerability,

the general public assumes, somewhat erroneously, that these women must also be highly protected. They assume that they are kept out of harm's way. People generally believe that no one can reach a person with a disability when they are so protected. They assume that no one could possibly abuse people in such a situation, and this creates a danger. Women with disabilities are not believed when they say they have been abused. Antigone, among others, was not believed, especially because "my parents wouldn't acknowledge that they did anything wrong, and everyone assumed that I was safe."

Another major belief is that women with disabilities are not sexual beings. Several things are relevant here. First, a number of the women talked about not being given sex education while growing up. Atalanta said, "I never was taught about sex." At a young age, the message was never to expect to have a sex life. Anyte was told by teachers, "You won't be doing that, so don't ask questions." The second important factor is that women with disabilities, lacking education, operate from a limited knowledge base. Due to a lack of education and experience, some women with disabilities may have more difficulty in distinguishing between appropriate and inappropriate behavior. Helios, for example, said, "We needed to have more education. What is okay? What isn't? We also needed someone to ask." Combine this with the necessity of some touch during personal care routines, and a situation is produced whereby the difference between good touch and bad touch may be very subtle. Demeter, for example, noted that, "if I'd known better, in hindsight, I would have called some of that earlier touch inappropriate." Helios

also said, "The touch may be for cleaning, but when a hand rests too long, or a finger moves around...what do you call that?"

The differences of disability can also result in being labeled as a "poor, disabled person," as was the experience of Artemis. Being seen as a pitiful thing and the object of charity kept her from feeling respected and whole. "I don't know. It's hard to feel like a whole person who is deserving of respect when people just pity you." However, those who labeled her felt they were being kind, and may have been shocked at Artemis' definition of the situation. "I hate when they do that! Who do they think they are?"

One consequence of the women's experiences not being viewed as "normal" is that abuse of people with disabilities may not be as glaringly obvious as it might otherwise be. Women in my study felt that many members of the public expect to see differences in behaviour around people with disabilities and may not view different behaviours, as exceptional or questionable. Electryon said, "They don't necessarily know what is normal care and what is abuse." Athena talked about this: "They already saw me as different, so how I was treated was seen as different from *their* experience, but not necessarily abuse."

Wolfensberger (1992), Waxman (1991) and Hahn (1988) all discuss reactions to disability that have a core of devaluation, hatred, and fear. People in general are afraid of becoming disabled, both physically and socially. They fear loss of "normal" functioning and question whether or not they could survive as a person with a disability, but also have knowledge of the low status afforded

people with disabilities. They also recognize that there are some people who actually abhor and hate people with disabilities as a group (Waxman, 1991), to having no conceivable use for them, and making no attempt to actually get to know individuals. The prevailing societal attitudes are of less value, prejudice, and discrimination. It has been said that no other group has experienced the same degree of devaluation over time and societies as people with disabilities (Waxman, 1991; Wolfensberger, 1992), and this is a significant factor in the fear of disablement.

Another notion about disability is the ableist bias in Canadian society. As discussed previously, to be able-bodied is the norm. Meanwhile, we all have some degree of disability (Klein, 1992); in fact, a continuum of dis/ability is more likely the reality. However, in our ableist society, degrees of ability are ignored, and disability is seen in negative terms. Negative attitudes and exclusionary practices result. Under the influence of ableist ideas, people with disabilities have no inherent value and therefore no true protection from abuse. At times, it almost appears that abuse of people with disabilities borders on being sanctioned. Athena, for example, said "We aren't worth protecting." That is a sad commentary on the state of affairs which the women then internalize.

Several of the women in my study felt that there is a prevailing public belief that it is permissible to abuse people who are inferior or disposable. Abusers may use this type of thinking to protect them from discovery. A number of the women felt that people with disabilities are perceived as inferior or disposable.

Demeter, for example, stated that "the attitude is that it's okay to demean people [with disabilities]." If someone or something is not highly valued, it is easier to accept negative treatment of them without major reaction or reproach. So, even if a person were caught abusing someone considered to be of less value, the sanctions would not be as great, if any.

Several women in the study felt that many people believe that all people with disabilities have mental disabilities, and also believe that those with mental disabilities don't have feelings or awareness. They felt that as a result, there is a related belief that people with disabilities will not understand or feel the negative impact of sexual and other kinds of abuse. Somehow this is supposed to make abuse more palatable. It is like saying "what they don't know won't hurt them" (Atalanta). It also reflects and reinforces the false belief that people with disabilities are less than human, and do not have normal human thoughts and feelings.

In sum, all of these beliefs reflect the erroneous and devaluing ideas which exist about women with disabilities. These beliefs add to vulnerability and also make it more difficult to respond to instances of abuse. These beliefs also undermine the credibility of women with disabilities and render their claims silent. In some cases, some of the women with disabilities in my study felt it was not even worth trying to make reports or do anything about abuse. Although non-disabled women generally are also subject to erroneous beliefs and stereotypes pertaining to being <u>women</u> in a patriarchal society, these disability-related beliefs add an extra

layer of potential disbelief and devaluation for women with disabilities. By virtue of being women first, women with disabilities are also subject to those stereotypes affecting non-disabled women.

6.4.10 DISABILITY-RELATED RISK FACTORS

There are a number of other factors and issues which were mentioned by women in the course of the interviews which seem relevant to the discussion. These have been grouped together as "disability-related risk factors." These include: vulnerability, credibility, limited education and employment opportunities, lack of self-esteem, medical domination, and socialization to be compliant.

Vulnerability

People with disabilities may in fact be less capable of physically or mentally resisting or getting away from a perpetrator, in the same way that some women have less ability to defend themselves or escape. The diminished ability is due to factors such as no arm movement, limited mobility, lack of strength or energy, difficulty communicating, limited mental understanding, visual and hearing impairments, etc.

This vulnerability is particularly the case for women with a highly visible disability, such as quadriplegia. For example, Demeter and Antigone both said that once they were out of their chairs, they were unable to move or defend themselves. Antigone said, "What are you supposed to do if you can't move? Once I'm in bed, I can't move." Demeter noted, "I don't know what I would have done if he wouldn't stop. Aside from my voice, there was nothing I could do to defend

myself or stop what was happening. I couldn't even move without assistance." This physical inability to move gets translated into "helpless victim." Perpetrators pick up on this inability to defend oneself when choosing a victim.

A number of the women believed that if they had not been disabled, they could have fought back or escaped. However, women generally are at a physical and size disadvantage compared to male perpetrators, and this disadvantage may not be fully recognized. There may have been less that they could have done even if able-bodied, but the women, particularly those with early onset disabilities, have no way of knowing that. The disability may play a role with regard to fighting back or escaping, but so does simply being female. Women are usually not able to fight back against larger, stronger, more prepared perpetrators. In some types of abuse, physical size may not be an advantage except perhaps in terms of an intimidation factor. Several of the women with late onset disability, who experienced abuse both while able-bodied and disabled, recognized that disability played a role in being less able to fight back or escape, but not the only one. Artemis, for example, said that the "abuse would have happened regardless; it [my disability] only made it easier." Others noted that it was made easier by lack of ability to move, to see, to hear, to comprehend, etc.

The vulnerability of women with disabilities is, to some degree, shared with other vulnerable groups, such as elderly persons and children. However, due to the added visibility and physical or mental limitations caused by some disabilities, some of the women

felt their vulnerability was heightened, and therefore, that they were at greater risk of being viewed as "easy prey."

Credibility

Another factor has to do with the disclosure of abuse and accountability for the abuse. There is a belief among the women with disabilities, which may also be held among perpetrators, that perpetrators will not be made accountable for their actions. This is due to the lack of credibility of women with disabilities. Women in the study said they knew, sometimes almost instinctively, that it might be futile or dangerous to tell someone about the abuse. They feared reprisals, punishment, or disbelief. This reluctance to disclose abuse was reflected by statements such as: "There was no one I trusted to tell" (Anyte), or "I just knew I wouldn't be believed" (Iambe). In some cases, the women tried telling someone, but were met with resistance. "They said I made it up" (Electryon), and "They didn't want to hear about it" (Hecuba).

The women anticipated that there would be less societal outrage when the victim has a disability. The victim also has less credibility by virtue of the lower status accorded someone with a disability. There may also be connections made between aspects of a disability and credibility. For example, those with mental disabilities, communication difficulties, or psychiatric disabilities may have their credibility questioned. Nausicaa expressed this belief by saying, "Because I had a psychiatric disability, my psychiatrist said no one would believe me anyway. So why report it?"

Lack of credibility, therefore, was a risk factor which kept some of the women in my study in abusive situations. Both actual lack of belief by others, and the women's own perceptions that they would not be believed, were equally important.

Limited Education and Employment Opportunities

The argument or belief that people with disabilities are innately different has been used to justify separate education. This may be in terms of the separate schools discussed by Athena, or the "special" education classes talked about by Helios, Electryon and Antigone, among others. They said that "special" was just a euphemism for inadequate. Antigone said, "Special education meant a lot of things. It meant separate and it meant less teaching. There weren't any standards or any expectations." They said that women with disabilities were treated as requiring different types of education based on perceived differences due to biology rather than on actual need. For example, someone whose legs didn't work was assumed to need special attention. This was supposedly done in order to deliver "better" and more specialized services, but in fact it shut people away and gave them what Electryon referred to as a "second class education, if you want to call it that at all."

This education was inadequate in being able to prepare these young women with disabilities to enter the "real" world. Helios described it as "putting in time -- spending more time playing games than anything else; a lot of people came out not even being able to read." The lack of preparation resulted in another source of low self-esteem, and gave one more basis of difference to other people

their age. Ismene said, "School should have been a place to gain confidence and self-esteem. But for us [students with disabilities], it's just one more difference."

This situation is beginning to change, but one respondent, who is just completing highschool, felt that the education received by people with disabilities was still inadequate and that disabled students were still kept separate within the schools.

Many of the women also spoke of the high rate of unemployment for women with disabilities. Nausicaa said, "There's just no getting ahead for us. We're kept dependent." Lack of employment opportunities is a systemic difficulty for women with a variety of disabilities. It is also more problematic for women than for men with disabilities (Ridington, 1989c). This systemic lack of employment opportunities maintains dependencies and limits self-esteem.

Limited education and employment affected the self-esteem and dependency of a number of the women in my study. They felt that this could add to the vulnerability and inability to react to abuse. It also made them more isolated. Although women do generally lack the educational and employment opportunities open to men, the women in my study were referring to aspects they saw as being specifically related to having disabilities.

Lack of Self-Esteem

Women with disabilities faced double discrimination--because they are women and because they have disabilities. In the face of both sexism and ableism, a number of women in this study believe

that self-esteem suffers.

The presence of a disability had a large influence on the socialization of the women. It negatively impacted on self-image and self-esteem. Despite this, a large number of women in this study said they were discouraged from actually discussing disability or disability-related issues both while growing up or while adjusting to a new disability. Artemis, for example, said "I was never allowed to talk about my disability, as it was upsetting to others." Being forced to pretend that a disability did not exist heightened the perceived negativity of the state of being disabled. It also restricted opportunities to share information and normalize disability.

Also related to low self-esteem was the lack of positive role models for women with disabilities. This affected both those with early and late onset disability. Due to isolation, and due to the lack of easily available or visible role models for women with disabilities (it was assumed that there were none), they had only negative images of women with disabilities to internalize. Athena said, "It was only when I came to the ILRC that I saw ordinary people with disabilities controlling their lives and doing well. Some of them were women doing quite well on their own." In the absence of real role models, they had to rely on knowledge of disability as given in the popular culture or as presented by the medical profession. Most of this was negative, demeaning, and/or clinical.

Almost all of the women with disabilities in this study said they heard and internalized a number of different messages, many of

which acted to lower their self-esteem. Examples included messages received by the women while growing up or while adjusting to a new disability: "You're such a burden," "Things are so hard for the family," "You're lucky to be alive," "We might all be better off if you were dead," "Be careful," "People will take advantage of you," "You'll grow up and old alone," "No one could possibly love you," "You're not worth much anymore," and "Listen to others--you can't possibly decide." All of these things contributed to the women being seen and acting as "easy prey."

Poor self-image and self-esteem, as reported by the women in my study, was seen as adding to their vulnerability to abuse. This was largely because they were devalued by others and also because they internalized this devaluation. The devaluation contributed to the "better than nothing" perspective revealed earlier.

Medical Domination

Medical domination is an important factor that influences how women with disabilities are perceived and how they perceive themselves. A false belief which has been created is that if you know a person's disability, you know everything you need to know about her. This reflects our society's value of the medical model, in which one of the most important steps is naming or diagnosing. People generally assume that knowledge of the disability provides knowledge of the person, and that if you know about the disability you will know how to act around the person, what to say and do, etc. This reveals several things. One is that people are viewed as no more than their medical conditions. The second is that it is assumed

that all people with the same disability act in the same way and have the same needs. For example, Atthis said, "All people with multiple sclerosis are assumed to be the same, despite a wide range of functioning." Because of this, a great deal of effort is spent getting to know about the disability, rather than getting to know the person. Several women felt that this takes away individuality, which they thought may increase their risk of abuse or decrease the comfort of other people in helping them.

Two women in my study talked about the inability of medical practitioners to "fix" people with disabilities. They observed that the medical system still holds great, if not ultimate, power and control. This power and control extends to caregivers who are designated by medical influence. Even though much of disability care and management has very little to do with the actual practice of medicine, the medical profession continues to be the regulator of the lives of people with disabilities. Therefore, to get a special needs allowance or extra bus tickets, a doctor's letter is required by the social assistance department, even though these are social, not medical, needs. Nausicaa, for example, said, "It's ridiculous that my doctor should have the final say in whether or not I get a blanket. It teaches people to disregard our opinions." Because the power and control is centralized with the medical profession and caregivers, there is an unquestioning acceptance that what they do is right and appropriate "treatment" and it is done in the best interests of the "patient." Antigone said "Even when they [doctors] were saying you should be sterilized for life, everyone thought that was good. I just

thought it was so final." Since what they do is couched in medical terms, there is a mystique about it to which the general public and some individuals defer. This means that members of the general public and individuals with disabilities do not have the expertise by which to judge the actions of the official regulators and caregivers. Only other "medical" personnel would be so qualified, even in instances of abuse. Thetis said, "No one would believe a doctor abused you."

This medical domination also leads people to believe that caregivers are trained, qualified, and competent, which may or may not be the case. It also leads one to assume that training and qualifications translate caregiving into professional, non-abusive care. To assume so would be faulty thinking. Demeter said, "When you're receiving care, you just assume that the providers are trained professionals. I learned the hard way that that means nothing." No amount of training or accreditation can remove the possibility of abuse. It may even shelter it from disclosure. When abuse happens, people are more likely to accept the word of a trained caregiver than the supposedly unknowing recipient of care. This sets up a dangerous scenario. Where abuse is found, it is also more likely to be defined as resulting out of frustration from the situation as opposed to occurring out of too much unregulated power and control. Electryon, for example, noted that "People assume your caregiver is a 'professional' and that because of that, would not--could not--abuse you. I know from experience that is not true."

People with disabilities and their families also come to accept

various medical opinions and treatments as truth and the only reality. Helios said, "My parents spent a great deal of energy trying to find medical solutions. They believed 'quack' doctors ahead of me." Medical opinion is still very strong, even among people whose disabilities are stable and western medicine has nothing to offer. It should be noted that most people with disabilities do not fit in the sick role, and do not have physical states of being that can be "fixed" by the medical profession. Doctors, occupational therapists, and other experts hold the keys to access many systems, including those which are not medical in nature. Thetis said "I had to go along with the Depo Provera because they said it was best. I might not have been let out [of the institution] otherwise." Medical service providers have a great deal of power over where and with whom, as well as with what supports, people live. Those who are dependent on others for physical care lack access to independent supports. The medical gatekeepers deem the number of hours of necessary service and for what those hours are used. People with disabilities may fear the loss of needs or services, especially in light of the limited alternatives, which may be imagined to be even worse.

Medical domination in the lives of women with disabilities may be another source of diminished credibility for women with disabilities. Medical and personal caregiving personnel also are believed to be "professionals" and as such could not possibly be the perpetrators of abuse. Therefore, in cases involving medical professionals accused of abuse, several of the women noted that most people would be more apt to believe the professional. Medical

domination in their lives has also served to keep women with disabilities disempowered, and also more separate than they perhaps needed to be. As noted by Sobsey (1988), this separateness increases the risk for abuse.

Socialization to be Compliant

In order to make caregiving and rehabilitation easier, women with disabilities are taught early on to comply with authority figures. This includes teachers, personal care attendants, bus drivers, parents, siblings, etc. They are told "You already cause extra effort," so they are taught to minimize how much they need or ask from others. In search of an "ideal patient," they are taught not to be demanding -- even in terms of having basic needs met -- and to be compliant vis-a-vis others. Helios, for example, had her fluids severely restricted, so that she would not have to be helped in the bathroom. Many of the women spoke of being taught to be passive and very grateful for any assistance and attention paid to them. Electryon noted that under the circumstances, "There was limited opportunity to develop personal power and control." She had one friend with a disability, who she said also told her to behave herself and not cause "trouble."

People with disabilities come to accept and not question typical ways of providing care. This is important, because people with disabilities often depend on the offender for personal care, and there may not be many other options. The home care system, as well as other configurations for care, give the caregivers an inordinate degree of control. Demeter, whose abuse was perpetrated by a home

care worker, said that "I was given the choice of lying in bed all day or of accepting their [the home care system] terms for who would do my care." Helios stated that "it doesn't always make you feel good, but it's the best you've got. You need to get dressed don't you?" Recent pilot project efforts (at the ILRC) in self-managed care, which put the person with a disability in charge, may begin to reverse some of this power imbalance. If nothing else, the individual will be capable of controlling who provides care and when this occurs.

There are many parallels between socialization to disability and socialization to be seen as a victim. This includes isolation, dependence on others, poor self-esteem, gratitude for care, lack of awareness, and compliance. These and other patterns increase the vulnerability to abuse by making it easier to victimize. The women either will not recognize events as abusive, will do nothing about them, or will not receive the support and assistance of others. Regardless of actual reality, women with disabilities are taught to, and do in fact, perceive themselves as "easy prey." Others, including families and perpetrators also learn this and believe this. In a "survival of the fittest" type of society, it seems "natural" that those "less fit" would be at the mercy of those more powerful.

These factors provide a context for understanding abuse and violence against women with disabilities. Although these factors are personalized for the women, many are actually social in genesis. They are created and sustained by how we value and treat women, and how we value and treat disability.

In comparing the information stemming from Figures One (p. 73) and Two (p. 170), we see that in terms of predisposing, or risk, factors women with disabilities in my study share many common factors to non-disabled women generally as noted in the literature. However, there are some areas of qualitative differences specific to the women with disabilities. These are particularly evident in the area of "fear of loss of children and keeping the family together," "dependency," and "fear of loss of assistance or services." There are also a number of specifically disability-related factors to consider. In addition, there are many perceptions, held by many of the women with disabilities in this study and, they perceive, by some people in the general public, that women with disabilities are very different, which may serve to further isolate women with disabilities and therefore increase their vulnerability to abuse. As noted throughout the narratives, there are a number of places where my data was absent or lacking, and this provides points of inquiry for future research.

6.5 THE IMPACT OF ABUSE ON WOMEN WITH DISABILITIES

This section examines the impacts of abuse and violence on women with disabilities in my study. Although all of the women did not experience all of these factors, the discussion provides an overall presentation of the range of impacts mentioned. This includes psychological and physical problems, denial of abuse, inability to identify and pursue non-abusive relationships, and what I call "blaming disability."

6.5.1 PHYSICAL AND PSYCHOLOGICAL PROBLEMS

Physical Problems

The physical problems experienced by the women as both direct and indirect results of the violence and abuse were quite similar to those noted in the general literature. Women in the study reported physical trauma, such as cuts, bruises, welts and broken bones. However, as noted by Atthis, "At least people believe broken bones. Plus, broken bones heal." Electryon and Artemis also talked about contracting sexually transmitted diseases as a result of sexual assaults. Electryon said, "It was horrible going to the doctor's--I felt so ashamed. I'm just thankful I wasn't pregnant as well." Atthis suffered a miscarriage due to the abuse she experienced. "I went into early contractions after one of his [my husband's] final beatings. I lost the baby. I'll never forgive him for that."

Some of the women also mentioned abuse which resulted in the creation or exacerbation of disabilities. For Thetis, she felt that the abuse may have actually contributed to her disability. She felt the abuse stressed her immune system and allowed her disability to take hold. She also felt that, "It made me crazy, which was what put me in the [mental] institution in the first place." This was also the case for three of the women who developed psychiatric disabilities and one who had developed arthritis. They felt that the abuse was instrumental in causing or "setting off" their disabilities, by creating intolerable situations or by weakening one's defense system. Thetis said, "If I'd never been sexually abused by my uncle

early on, maybe I wouldn't have felt so different from everyone. My depression was only natural." A number of others felt that the strain of dealing with abuse definitely worsened their conditions. Iambe said, "I can't but wonder if he [husband] hadn't been so abusive and worked me so hard when I should have been resting, maybe my arthritis wouldn't have got so bad." Artemis also felt that her condition due to multiple sclerosis was severely strained by the abuse. "I can't take a lot of stress. It takes a lot out of me, and I need all of my energy just to survive from day to day." Caritas said, "My health is going down--it's getting worse; and I think it's all related to the stress he [my son] puts me under."

Psychological Problems

Some of the problems were more indirect. This includes sleep disturbances, depression and dissociation, self-harm and suicidal tendencies, and substance abuse. A number of the women talked about not being able to sleep and having feelings of depression. Cyrene, for example, said, "Even now I cannot sleep well. I fear they will come and get me. I wake up in a cold sweat." Electryon said, "I just can't get past it. It's like a black cloud that hangs over me. I hang in for a while and then I'm back in crisis." Several women discussed feeling so badly that they would resort to self-harm. Helios recalled, "I was very destructive--I'd bang my head, slash, even tried to choke myself." Electryon also said, "Suicide seems like such a good answer to the pain." Hecuba noted a different kind of pain. "I've been working to heal the dissociation which I've had as a result of the childhood sexual abuse." Thetis, Erinna, Electryon and

Nausicaa also reported abusing prescription drugs and alcohol. As Erinna noted, "I suppose it didn't really help, but it eased the pain."

Loss of Self-Esteem

It may be impossible to sort out the respective effects or impacts of abuse and disability. I did not ask specifically about this, and the women did not speculate on this. Both disability and abuse are threats to identity and self-esteem and impact negatively upon the women. These are synergistic effects which are hard to separate. Future research should try and ask separately about these impacts, in order to distinguish between the effects.

A threat to identify formation was the presence of abuse from an early age. Erinna had referred to this when she talked about being beaten down from an early age. A number of women perceived that much of this abuse was directed at their disabilities, especially the verbal and emotional abuse. However, they did note that they could not say for sure that it was directly connected to their disabilities. For example, Antigone questioned, "Who knows whether it was the disability or the abuse? Both lower your self-esteem."

Abuse is related to low self-esteem. The direction of this relationship is unknown. "Whether women of low self-esteem are likely targets for battering relationships or that battering relationships cause low self-esteem is not entirely clear" (Aguilar and Nightingale, 1994: 35). Artemis wondered "Whether it was the abuse or early lack of self-worth that caused me now to have low self-esteem. I wonder what the connection is between the two?" It is likely a bit of each, but what is very important to note is the

particularly common self-perception of low self-esteem of women with disabilities in my study. Low self-esteem among women with disabilities was explored in a fair amount of detail in the literature review, and will not be delved into again at this point. Also, future research might include systematic measurement of self-esteem, perhaps comparing women with disabilities who have and have not experienced abuse. Comparisons might also be made to women who do not have disabilities. However, it should be noted that due to low self-esteem, many of these women with disabilities see themselves as likely targets for battering relationships or other types of assaults.

For those with early onset disabilities, six had experienced abuse starting at an early age and continuing into adulthood; one had experienced abuse in her late teens/early adulthood; and two had experienced abuse only as adults. Several women said they felt that the very early abuse takes an even greater toll, and this is consistent with the literature (Lonsdale, 1990; Doucette, 1986). Several of the women with early onset disability and early experiences of abuse also made comments that gave the message that their disabilities were bad and were to blame for the occurrence of the abuse. This included things like "if I hadn't been disabled, it wouldn't have happened," or "they [my family] blamed everything on my disability" (Helios). Without having access to alternative explanations, disability became equated with "bad." As noted earlier, abusive behaviours and events were normalized. A number of the women in my study felt that it was hard to

distinguish why the abuse was happening, and with negative messages from parents, siblings, and others, the natural consequence for a number of them was to blame the abuse on their disabilities.

The most commonly voiced impact of abuse on the women in this study was the loss of self-esteem and self-confidence or the inability to develop positive self-esteem. However, it is hard to separate the low self-esteem due to growing up or living with a disability and the low self-esteem and confidence which result from abuse. This may be because, for many of the women in my study, having a disability meant being subjected to high levels of psychological and emotional abuse. The two were synonymous. Thetis commented: "Between my disabilities and the abuse, it's been really hard to feel good--both batter self-confidence and self-esteem. I never really ever had a chance to develop a good sense of who I am." Hecuba said, "I never felt good enough. I felt like I was doing something wrong just by being alive."

For many of the women with early onset disabilities, the emotional and psychological abuse and the use of negative language began at an early age. This made it very difficult, if not impossible, to develop a sense of self-worth. Even when the negative messages did not directly name the disability factor, the underlying message was clear. This was mentioned by Electryon, who said, "You just knew it was bad to have a disability. No one thought you'd amount to much." Both the abuse and the negative messages about disability were threats to self-esteem and the development of a healthy self-

image. Several of the women appear not to have been as negatively affected by it in the long run, but they could not verbalize why they were able to escape the harmful effects, except to say that perhaps they were able to get better help in dealing with the abuse.

Early practices, which a number of the women defined as abusive, sent important messages. For example, several women spoke of the fact that when they were born, there was none of the typical celebration which accompanies a birth. Instead, a deathly sadness surrounded the birth, along with pity and grief. This gave them an early and strong message that disability was bad. The women discovered this when "comparing notes" during a peer support group meeting held as part of the ILRC abuse project. Helios said, "This was the start of many abusive messages that said being disabled is the worst possible thing."

Emotional abuse directed at one's disability certainly impacts on the women. Cyrene, for example, related that "You feel you don't belong just because you walk different; they just want to put you down." Thetis recalled that as she became progressively more disabled, people around her, most notably family, really felt that her life was soon to be over and not worth living. Anyte reported that people she encountered felt that it was a waste of medical services and dollars to care for people with really extensive disabilities, and perhaps "they would be better off dead." Ismene philosophized about this aspect and said "I think it's because they try and imagine being like me -- probably during a nightmare -- and they just can't imagine coping." All of these scenarios were described as being

emotionally abusive, although a number of the women felt that because these are "normal" ways of thinking about disability, most people would not acknowledge these as abusive acts.

Helios felt that societal devaluation, which she saw as a "blatant form of emotional abuse," led to her own internalized hatred. She conveyed the effects of hearing those negative messages over and over again without positive counterbalance. "Being disabled and not having anyone to look up on, you come to see how being disabled was the worst possible thing in life." This also reflected the lack of positive role models for women with disabilities. As a result, she was very destructive to herself from a fairly young age, revealed by behaviours which ranged from head banging and slashing, to pill overdoses.

Artemis noted that there was an extremist kind of thinking at work regarding disability. "You're either a 'poor disabled person" or you're a 'Rick Hansen superhero.'" Of course, women with disabilities rarely achieve hero status, which leaves them to be viewed as "poor disabled people." And, she said, "Whether people like it or not, that thinking is abusive."

If we come to see ourselves as we imagine others see us, then women with disabilities probably come to see themselves as weak, not whole, not valued, dependent, undesirable, and burdens to others. Several of the women felt that other people thought of them in these terms, and that the resulting actions and beliefs were abusive. Helios said, "My family made it clear that I was nothing but a burden to them. I held them back, yet they were still there, and for that, I

should be grateful." Caritas shared, "Of course they all think we're weaker and less able to do things. That's why they leave when we can't do it anymore."

Amphitryon noted that it was especially "hard to deal with abuse and a new disability at the same time." In those cases, the combination is like a double "whammy." She said that both felt quite abusive to her. This, she said, can be quite devastating to one's self-concept.

Again, it is difficult to discern the impact on self-esteem. For those with early onset disabilities, is the abuse or the internalized negative attitudes about disability most damaging to self-esteem? For those with late onset disabilities, is it their own attitudes, societal attitudes, or changes in functional ability which affect self-esteem; or is it the abuse which leads to such low self-esteem? These are hypothetical questions, which may be very difficult to answer due to the synergism in effect.

Helplessness and Hopelessness

Feelings of helplessness and hopelessness encompass a number of impacts noted by various women in my study. These impacts include shame, humiliation and self-blame. Caritas said, "I felt so badly. I was ashamed and I didn't want anyone to know what was happening." The self-blame was exemplified by Ismene, who said, "I thought everyone would think it was my fault. I guess in a way it probably was." She felt it was her fault because her disability made her a hopeless burden to others.

A number of women reported feeling helpless and trapped, with

no options or possibility of escape. Electryon said, "There was nothing I could do. I couldn't get away--couldn't escape. If it were to happen again, I'd still be helpless." Anyte voiced her concern about the lack of options. "Having a disability meant you didn't have a lot of choices. So you stayed in it [the abusive situation]." Staying contributed to feelings of hopelessness among a number of the women.

Isolation and Dependency

Another fairly common effect of the abuse was further isolation and increased dependency (often on the perpetrator). Several women talked about how the abuse isolated them even more than they already were due to their disabilities. Iambe, for example, felt more and more alone as the abuse went on. "I knew there was no one I could turn to. I was all alone--with him." Antigone said, "The more alone I felt, the more I had to depend on them [my abusive family], which let them abuse me more." By virtue of her physical dependency, and the lack of support options, she felt she became more dependent on the perpetrators of her abuse.

Fear and Anxiety

Due to threats and actual assault to the body and the psyche, many of the women had high levels of fear and anxiety. Some women were very afraid of strangers hurting or taking advantage of them. Cyrene told me that, "The world is a very unsafe place, especially for those who are different like me." Atalanta said, "You have to be very careful. I don't go out by myself anymore."

For some, the fear and anxiety was not fear in relation to

strangers, but family. Helios, for example, said, "I won't ever let myself be alone with my parents. It's just not safe. I feel better out on the streets." Also, as noted by Antigone, "People don't understand when you say that you're scared of your family. You're taught to fear strangers." Athena said, "I was so afraid of future retaliation from my family."

Damaged or Destroyed Trust

Noting abuse by those in positions of trust, such as professionals, service providers or family members, several women talked about damaged or destroyed trust. Athena, for example, said, "It was a real abuse of trust. As part of his work, he was able to take advantage of me. I can't trust any of the drivers now." Electryon, Helios and Antigone all related being unable to trust family. "It really hurts when it's your family. I don't know if you can ever get over that to trust anyone."

This factor is also significant in that it is related to difficulty with self-esteem and in forming relationships with other people. As is the case for non-disabled women who have experienced abuse, this results in further isolation.

All of these physical and psychological impacts affect the women in negative ways. Although many of these are shared by women generally, the women in this study felt that some aspects, such as emotional abuse, were made worse by the presence of disability.

6.5.2 DENIAL OF ABUSE

A common reaction to the abuse was denial or "explaining away" of the abuse. This denial was enacted by the women themselves and by others.

Denial by the Women

It is interesting that where possible, many of the women looked for the availability of alternate explanations for the abusive behaviours of others. They would try and interpret or call what was happening many different things before calling it abuse. They tried to normalize it. Antigone said "Abuse is such a bad thing. No one wants to be ABUSED." Yet naming it as abuse is a first step in being able to deal with it, and people with disabilities are often offered a plethora of other explanations first. For example, "They're doing this because they love you," or "It was just a medical treatment that they felt was best," or "You must have misunderstood." Other explanations included being stressed out. Helios said, "My family just couldn't handle the stress of dealing with my disability. That's probably why most of it happened." Anyte also talked about the role of frustration. "When they got frustrated they'd be more likely to lash out and hurt me." Amphitryon saw it as love. "If he didn't care about me, he wouldn't even bother." Finally, the alternate rationale for some was that they were deserving of the abuse, or that was all that could be expected. Erinna repeatedly found herself in abusive situations with abusive partners, and she believed that, "Having a disability, I couldn't really expect much else. I sort of deserved it--for the choices I made in life." She felt that because she chose to be

with these men, she deserved the consequences, even when the consequence was abuse.

What were some of the other day-to-day reasons or rationales given for the abuse? Anyte felt it was because "Parents can't handle it; it's easier to abuse the child than to deal with why the child is disabled." Abuse was viewed as an inability to deal with the reality of disability. Hecuba felt that she was emotionally abused and neglected because she had a disability. "Initially I thought it was my fault because of my disability and that they did it to me out of disgust [with the disability]." Cyrene said abuse occurred because people were not accepting of differences. Artemis put her opinion very bluntly: "People will do things if they feel they can get away with it." Sometimes bad memory, lack of vision, and impaired mobility were cited as increasing the confidence of perpetrators to believe they could get away with it. Nausicaa echoed this by saying, "Because people believe they can get away with it. That people with disabilities won't talk or be listened to."

As noted by Kelly (1988), naming is a very important step in coming to terms with abuse. However, an important requirement is knowledge--which was lacking for a large number of the women in this study. Generally, there is a lack of knowledge about what constitutes abuse. This is the case both in the public sphere and among the women with disabilities. To a large extent, abuse is a taboo subject.

For women with disabilities, this is even more the case. Helios said that it was not until she did the ILRC Abuse Survey that

she began the actual process of naming her abuse. Up until then, she knew that these events and behaviours had not felt right, but she had not termed them "abuse." Lacking awareness, a number of the women said that only physical or very extensive abuse was really labelled as being abuse.

It is significant that people are taught so very little about abuse and how to recognize or deal with it. Almost all of the women said there was a need for a significant amount of education. Electryon said, "Almost anything is better than the nothing we get taught about abuse." This lack of awareness breeds isolation and silence. As noted by Ismene, "Staying silent was like allowing him [the perpetrator] to get away with it." If people were taught more, they would feel entitled to talk about it, and would be more aware of what to do in the event of abuse.

It should be noted that many people with disabilities are not educated about abuse due to beliefs that people with disabilities could never be abused. This ignorance puts them at risk of further victimization and may prevent others from reacting to abuse when it does occur. Atalanta, in hindsight, noted that perhaps she "Should have known better than to go with him. He wasn't really someone I knew." However, she was never given any reasons to doubt the intentions of others. Demeter said that "When there is such a fine line between personal care and sexual misconduct, we need to know more, in order to make intelligent calls of the situation."

Also similar to Kelly's (1988) findings, women in this study were prone to minimizing and forgetting about the abuse and its

impact. Electryon, as an example, said, "I don't know. I suppose it could have been worse." Atalanta noted, "I never really forget. But I forget how bad I felt at the time." Sometimes the forgetting is more a lack of memory. Hecuba said, "I know it happened--at a young age --but I really can't recall details." This loss of memory probably served an important protective and coping function.

Denial By Others

In addition to the denial by the women themselves, was denial by others, such as family, outsiders, caregivers, perpetrators, etc. This includes a denial that it was abuse (or offering alternate rationales), a lack of acceptance of responsibility, and a lack of recognition of the impacts of the abuse.

Many people believe that abuse and/or violence are relatively rare. This belief holds true despite the frightening statistics noted earlier in the literature review. As a public we deceive ourselves. Perhaps this is because it would be difficult to function in a world if you were to believe that one in four girls would be sexually assaulted prior to age 16. Perhaps it is because we do not want to address the problem. It is also difficult to believe that for women with disabilities, the rate of abuse is 1.5 to 2.0 times greater than for non-disabled women (Sobsey, 1988). This is likely a conservative estimate. Despite the general belief that abuse of women with disabilities is relatively rare, 40% of women with disabilities in one study had been abused, raped or assaulted (Ridington, 1989b). It is easier to put our collective heads in the sand or look the other way. Or, it may be a reflection of our

propensity to view things as private troubles rather than public issues (Mills, 1959).

Another relevant belief is that people with disabilities are not abused, especially sexually. This is the same type of thinking which would have us believe that no one would abuse a child. The reality is that it does happen, and our hoping it not to be that way does not change reality. The literature clearly shows the rates of victimization. A generalized belief to the contrary serves only to invalidate the experiences of people with disabilities, or to couch what is happening to them in more pleasant or socially acceptable terms. For example, several of the women talked about their abuse as being "discipline" for things such as incontinence, drooling, or muscle spasms. Helios related, "Not only did they [my parents] restrict my fluid intake to less than a cup a day, and made me feel bad when I had to go [to the washroom]; but they also punished me for incontinence. They said this would teach me not to do it." Terming it discipline instead of physical or emotional abuse gives it an air of acceptance or justification. Sometimes is it done to protect the perpetrator. An example of this is how professionals try and explain away incidents of professional abuse by saying the individual must have misinterpreted the action, or that they were mistaken. For example, although Thetis experienced the use of Depo Provera and other medical judgements as abusive, she related, "My doctor said they were only doing what was best. If I thought there was something done wrong -- I was mistaken. Yet they ignored my side-effects, questions, and concerns." The reality is that if the

person experienced the action as abusive, it must be real to them.

The second part of this belief is that people with disabilities are not abused in a sexual way. Women with disabilities are not generally viewed as being desirable sexual partners, not even for forced sexual encounters. There is a feeling, stated Nausicaa, that "no one would be desperate enough to rape a 'cripple'." Women with disabilities, as they are often viewed as children and asexual, are seen to be innocent and not sexual beings -- in any capacity. Anyone who would violate such innocence would be truly vile, and therefore it is even more difficult to believe that it does in fact occur. It would be too difficult to accept.

Another way of looking at the denial or disbelief was people offering alternate explanations for events. Athena found that social workers said that the emotional and verbal abuse "maybe happened out of fun." Other explanations point to stress and blowing off steam. Electryon said that transitional housing workers explained the abuse as: "Maybe due to it being a very emotional situation all around. Things get out of hand at times like that." She also felt that staff did not want "to rock the boat." Helios remembered abuse being blamed on the stress of disability. "Apparently they [my parents] just couldn't handle my having a disability. So everything was taken out on me when things went bad." These explanations were easier to handle than actually acknowledging that abuse was happening.

Several of the women felt that there is a view among some people that caregivers are "charitable martyrs." This permits

rationalization, so that even when there is a discovery of abuse, there may be a reinterpretation of the abuse, such that there is less societal outrage about the abuse. This reinterpretation occurs because some people cannot picture themselves caring for a dependent child or adult over the years. Therefore, they may assume that whatever abuse occurs is a normal reaction to stress, and that the caregiver should actually be commended for coping so long, and not prosecuted for his/her wrongdoings. This has been called the "dependency-stress model of abuse" (Sobsey, 1990; Steinmetz, 1983).

Helios recalled her mother saying things to her like, "If God doesn't strike you down, I will." Yet, at the same time, her mother was generally viewed as being a good mother who graciously took on the care of her daughter at home, despite the obvious difficulties. Helios told several people about this, and they felt that it "must be hard for everyone concerned." Beliefs about what the stress and frustration of the situation must be served to stretch the limits of acceptable human behaviour. Normally, this would not be an acceptable thing to say to a daughter, but because of her disability, the response was empathy rather than surprise or outrage.

Ours is a victim-blaming society (Ryan, 1971) when it comes to abuse. We tend to see abuse as due to the actions of an individual victim. For example, in rape cases, the victim is blamed for wearing her skirt too short, or because the woman should not have been walking alone at night, etc. Thetis, said, "People thought it [my rape] was my fault. That I did something to lead him on or somehow

ask for it." It is easier to blame the victim than to view rape as a crime of violence and a crime of male power and domination. We do not look at the societal forces, such as patriarchy, which feed abuse and violence. It is easier to blame it on someone who is already powerless and less likely to speak out -- the victim, than to address these larger systems.

The perpetrators benefit from and feed on this lack of credibility and powerlessness. As an example, Erinna's partner used to "Blame my bruises on my seizures. No one believed he hit me." Her partner was perceived to be more credible than Erinna. Many people are willing to accept this denial of responsibility, wanting to believe that everything is fine.

There was also a denial of the impacts of the abuse. Erinna, Ismene and Nausicaa all expressed similar recollections about how people responded to their sexual abuse. Responses came from a combination of family and service providers. Ismene summed the opinions up by saying, "They said I was lucky to have anyone interested in me. As if rape showed interest!" This reflects a more general belief that no one would value or be sexually interested in a woman with a disability. It also leads to people not understanding the impact of abuse and devaluation. Hecuba, for example, had people say to her, "Get on with it already--that was a long time ago." They felt that the implication was that the impact of their abuse was minimal and should no longer be significant (if it ever was viewed as significant in the first place).

6.5.3 INABILITY TO IDENTIFY, AND PURSUE NON-ABUSIVE RELATIONSHIPS

As for women generally, a number of women with disabilities in my study discussed having an inability to identify and pursue non-abusive relationships. Several saw sexual violence in particular (especially incest) as a future vulnerability to sexual and other types of abuse. For example, Helios said, "I'm sure the incest made it harder to avoid abuse later on. It was like the start of a roller coaster ride that you couldn't stop."

One important difference to the situation noted for non-disabled women is that the relationships spoken of by women in my study were more often involving family members rather than intimate partners or lovers. (I should note that I did not ask the women specifically about relationships, so this information is based on what women happened to offer during the course of the interviews.) For some of the women with disabilities, there are also significant relationships with family and other people, who may be present in a caregiving capacity. The difference to other non-disabled women is that non-disabled women are generally the care-givers; women with disabilities tend to be the care-recipients. So although both are in close relationships with other people, the nature of those relationships is an important difference.

In terms of relationships with families, a number of women in my study made comments. Helios noted that, "I was really dependent on my parents--more than other kids, because of my disability." Antigone said, "I wish I could break it off with my parents, but I

can't. Yet I'm starting to see that what's going on is just not okay for me." Caritas, referring to her relationship with her son, said, "I don't know why I can't break it off. Maybe I'm afraid of being alone." The women who talked about this felt that they were stuck in relationships with their families, and factors such as disability (which made them more dependent) made it harder to break away.

A combination of factors hinder the women's abilities to identify and pursue non-abusive relationships with partners. In addition to the "normal" difficulty in changing or breaking off relationships, particularly long-term ones, are several related to growing up or living with a disability. First is the idea that "No one else would want me," which was expressed by a number of the women. They felt that then they would be alone. Second is the extra pressure put on women with disabilities to conform or pursue "normalcy," which includes pressure to engage in the compulsory heterosexism of our society. In a struggle to be "normal," women with disabilities strive to be engaged in heterosexual relationships. Amphitryon said, "To try and be normal, you had to have a boyfriend, even at the risk of being beat up. You tried extra hard because you were disabled." Finally, if you believe that the basic components of normalcy are present, and if you lack the confidence to believe you will ever successfully enter another relationship, why would you pursue anything else? Anyte said, "I wasn't about to risk losing this relationship--even when I finally became aware that it was bad for me. I might never find anyone else." A number of the women are trying desperately to pursue "normal" relationships, but due to both

their disabilities and their abuse, they don't know what they are.

Repeated abusive experiences, combined with low self-esteem, normalizes abuse over time. Erinna, for example, said, "I don't know what it is to be in a healthy relationship really. abusive ones are all that I know. I think it has to do with my not thinking I deserve better." Additionally, many of the women lack healthy role models for positive relationships. Hecuba said that "I never saw a model for a good relationship with my parents. And other women with disabilities were either alone or with guys who weren't that nice." These conditions reinforce their negative interpretations of themselves, and lead them to stay in bad situations which are viewed as "normal." If you saw your situation as normal, why would you attempt to change anything?

6.5.4 BLAMING DISABILITY AND THE ROLE OF "EASY PREY"

A number of the women in the study referred to their vulnerability to abuse as "easy prey." They also believed that their disabilities were to blame for the abuse and that their disabilities made them more vulnerable.

A commonly accepted reality is that abuse is inevitable and people with disabilities, especially women, are "easy prey." As Hecuba noted, "Everyone knows we are 'easy prey.'" This was mentioned in other ways by almost all of the women, although others used words like "targets," "marks," or "vulnerable." If they did not describe themselves as being "easy prey," they did still perceive women with disabilities generally as being so. Artemis, for example, said, "I try not to worry about myself too much, but I know

it's a problem for other women with disabilities."

Some of the risk factors connected to specific disabilities, mentioned by the women, included: the inability or impaired ability to communicate, lesser energy levels or strength, reliance on others for direct care and assistance, lack of mobility, vision and hearing, and inability to fight back or get away. Amphitryon, for example, said "Things were different before the accident. Now, I wouldn't have a chance."

Although visible vulnerability may provide an increased opportunity for exploitation, many of the women, regardless of type or degree of disability, believe that as women with disabilities, they are all equally vulnerable. A number of women in my study felt that this idea that disability equals vulnerability or easy prey has become a commonly accepted reality regardless of individual differences and circumstances even among members of the general public. This notion is seen as the natural way things are, since a disability is perceived to make one weak and therefore a target for abuse.

We generally view sexual assault and abuse as being motivated by sexual urges and uncontrolled (or uncontrollable) desire. This, when we consider the low level of perceived desirability of women with disabilities, multiplies the disbelief that anyone would sexually assault a woman with a disability. However, if we view these as acts in terms of a need for power and control, then women with disabilities are more believable victims. Many women with disabilities <u>appear</u> to be physically easier to overpower, and due to

many factors in their socialization (noted earlier), may in actual fact be easier to control. Thought of in this way, women with disabilities move from being unlikely targets to being very likely targets. Amphitryon said, "No one believes we get raped, yet we do -- a lot."

Offenders look for targets they perceive to be passive, easy to control, and vulnerable. Women in my study believed that other victims, offenders and the general public all see children and women with disabilities to be vulnerable, passive, and easy to control and therefore "good victims." Cyrene said, "I'm always living in fear, knowing my vulnerability because I am disabled." Neither group (women with disabilities or children) has yet developed credibility as witnesses, and this may increase their vulnerability. These factors would make both groups easy marks or targets. Often no one suspects the offender, and if they do, no one believes the victim, as they have less credibility. It is a perfect situation for abuse.

Because people with disabilities may be seen as less -- less human, less productive, less feeling -- they may come to be viewed as burdens. Helios said "Disability is a real problem for my family." Electryon shared that "I always felt like I was a lot of trouble to my family -- a big burden, for which they would never forgive me." Atalanta told me that "My parents loved me, but I think it was hard. They had to watch me a lot." This conception of less may become a justification for receiving fewer services, less protection, etc. Electryon said "I think my parents wondered sometimes if it would be kinder if I were dead."

Examples such as this reveal two things other than devaluation of people with disabilities. One is that it is not uncommon or unacceptable for other people to make monumental decisions in the lives of people with disabilities (Senn, 1988; Sobsey and Varnhagen, 1988). Nausicaa, for example, revealed that it was family members along with her doctor who felt that she should not be allowed to have children. The second is that even when a horrific criminal act does occur, there may be a reinterpretation of the event, in order to make for a better fit with supposed humanitarian ends (Sobsey, 1990). Nausicaa, for example, said, "It's like they are seen as martyrs. What they do is never wrong." Hecuba also said, "Although we get smothered or treated as incompetent, it's seen as justifiable--it's for the best. No one really believes that there's anything wrong with that."

Many of the women felt that offenders will look for the most obviously easy targets as victims. There were quite a number in this study who felt that women with disabilities were the most visible of available women targets. "By virtue of our disabilities, we look very different, and this sets us up for abuse," said Anyte. Caritas was of a similar mind, saying, "The person can't fight back, or maybe the person who is doing it thinks the person with a disability is stupid or something." Abuse is seen as an almost inevitable occurrence when there is a perceived or actual difference in strength and power between individuals or groups.

Despite this perceived inevitability of abuse, there is still a reluctance on the part of the larger society to believe that someone

would abuse a person with a disability. Ismene, for example, thought, "There were lots of people out there who felt it couldn't possibly be true [that he raped me]." Reasons included that the person with a disability was not seen as attractive, the offender "couldn't be that desperate," or the belief that childlike innocence protects people with disabilities. People don't generally think of the underlying reasons; they think people with disabilities are safe from abuse.

Some saw that it was the timing of events that was important to blaming the abuse on disability. Atthis recalled that "When I needed to use a wheelchair [because of the M.S.], he [husband] kicked me out and took the kids away." When she could no longer serve him, she was treated as disposable. It was hard not to see this timing as coincidental.

Overall, it is interesting to note that those who knew of non-disabled peers who were also abused were less likely to blame their disability for the abuse, although some still felt that disability made it easier to abuse. Low self-esteem and self-worth were also viewed as factors related to disability in our society. Several of the women felt that lack of confidence and belief in oneself facilitated abuse, by making women better victims.

In sum, there is a perception that women with disabilities are "easy prey," which when coupled with other kinds of devaluation and negative messages about disability, results in many of the women blaming their experiences of abuse on their disabilities. The women

come to believe that they deserved the abuse because of their disabilities or because they were individually vulnerable. Women with disabilities may act in ways that fulfill these role expectations (i.e., there may be a self-fulfilling prophecy), and are in fact easy prey in some ways just as other groups such as children and elderly persons are. However, that this is a socially created phenomenon is rarely perceived by the victims. Instead, they see being "easy prey" as an individual problem which would suggest the pursuit of individual solutions.

As can be seen, abuse and violence have significant effects on the women in this study. Many of the impacts are similar to those experienced by non-disabled women (as found in the literature), although some differences were noted. Physical and psychological problems were very similar, although a few of the women talked about their disabilities being set off or made worse by the abuse. Denial of abuse was another shared impact, although the women in my study noted some differences to the general literature. Inability to identify and pursue non-abusive relationships was also similar, although for many women in my study, particularly those with early onset disabilities, they were not in "partnered" relationships and referred more to relationships with family members. Finally, a number of the women talked about perceiving themselves and other women with disabilities as "easy prey." Next I consider possible interventions.

6.6 INTERVENTIONS

As noted, interventions are intended to slow or stop the cycle of abuse and violence, by addressing the causes or responding to the abuse and violence. In this section, I examine the formal and informal sources of intervention and support. I then explore the question of whether interventions developed largely for able-bodied women are adequate for the needs of women with disabilities.

Before beginning, I would like to note that an important requirement for action is that women with disabilities and others around them name their experiences as abuse or violence. As this aspect is limited, for reasons explored earlier, interventions are also limited. In addition to needing information about the availability of resources, women with disabilities also need to know that the resources are required because what they are experiencing is abuse or violence and it is wrong.

Although I attempt to separate the formal and informal interventions to follow the categories found in Figure Two (p. 171), the women in my study lumped together community resources such as social services, the police, courts, etc. They spoke generically about community response because they were not asked specifically about various components. Therefore, specific information on interventions is limited. Future research could look at separating these and ask specific questions about each area of possible intervention.

6.6.1 SOCIAL SERVICES

The underlying belief that women with disabilities will not be abused is also reflected in community services and resources. There is a lack of accessible services for victims of abuse who have disabilities. There are only three services in the City of Winnipeg which provide services which can be said to be highly accessible to women with a variety of disabilities (as assessed by the ILRC Abuse Project). These are: Osborne House, a battered women's shelter, which has one wheelchair accessible room and a TTY on its crisis line; Klinic Community Health Centre, which provides counselling and crisis services, and is wheelchair accessible and has a TTY; and Fort Garry Women's Resource Centre, a community group which provides information, referral and counselling, and is wheelchair accessible and provides a TTY. To be totally accessible would mean providing a range of accessibility, such as wheelchair access, TTY phone hook-ups, transportation assistance, sign interpreters or attendants, and experience in working with people with various disabilities, etc. Even with the three services named above, their capacity to provide service is limited. Part of the problem relates to physical access (e.g., Osborne House only has facilities to house one woman requiring wheelchair access at one time) and part relates to attitudinal factors. Two examples were brought to my attention during the course of the ILRC Abuse Project. In one case, Antigone said that "A number of years ago, I tried to find a place to go, to escape and get counselling, but they all turned me away because I couldn't get in and they didn't know what to do for me anyway." The

second example was a woman who called the Centre asking for help. She had just called Osborne House for help and was told that the wheelchair accessible room was already in use. Several phone calls on her behalf resulted in action being taken by management to provide service in an alternate location. This creativity solved the problem, but points to the need for further training of front-line workers.

When staff from the ILRC asked about past experiences of community service providers in working with women with disabilities, we found only limited experience. A number of service providers expressed hesitancy about their ability to "handle" women with some disabilities, such as those labelled mentally handicapped or those with psychiatric disabilities. There is also a lack of awareness, by service providers and many people with disabilities, of what is actually available and accessible. For women with disabilities, who may be socially isolated, awareness is even more limited. Most of the women with disabilities in my study were not aware of what community resources were available.

People with disabilities generally accept that services are not accessible, rather than questioning and demanding greater access. This creates a situation where many women remain in situations rather than get out, in that there is a perceived dearth of accessible places to call upon. The lack of accessibility and barriers noted by the women in the study included: lack of wheelchair access (stairs, no elevator or ramp), lack of TTY's for deaf women, no accessible, available or affordable transportation, no available personal care

attendants, and lack of specific knowledge about disabilities, or patience to learn. As noted by Thetis, "Things like this make it so much harder for us to ever get help."

A number of the women in the study said that attitudinal accessibility may be an even greater barrier than physical access. This refers to the willingness to serve women with a variety of disabilities. Fueled by a lack of awareness and the influence of medical practitioners, community service providers have come to believe that a high degree of specialized expertise is required in order to deal with the supposed uniqueness of disability. Some service providers believe it takes special skills to deal with someone who has a disability, even when the disability is not particularly relevant. Disability is not irrelevant to the abuse, but it is sometimes irrelevant to service provision (i.e., service providers should be sensitive to their needs, but this does not require medical expertise and training). Several of the women in my study felt that service providers required sensitivity to their disability-related needs and experiences, but that medical professionals were not what they required. It appeared that with regard to services, a number of the women wanted to be able to say: "I'm a woman who has been abused; I just so happen to have a disability." However, several women with disabilities in my study relayed that service providers who provide services to people who have been abused often lack confidence when confronted by a person with a disability, and they lack confidence in their ability to assist the individual who has a disability. This was particularly the case

for women with quite severe physical disabilities, or those who had seizures, or mental and psychiatric disabilities. Amphitryon said, "I was automatically sent to the hospital [after being abused] because of my disability--I think people were scared to deal with me [due to the extent of my physical disabilities]. Yet what I really needed was a good counsellor." Erinna felt she was turned away from the local shelter because "They thought I would have a seizure and that scared them. So they thought I needed a doctor." Medical services are viewed as the best resource for abused women with disabilities, despite the relative lack of expertise of hospital-based medical personnel in the area of abuse as compared to people who deal primarily with issues of abuse in the community.

Another problem is that resources in the community are viewed by many of the women as funded to focus on partner abuse, battering, and sexual assault. Yet for women with disabilities, there are other forms of abuse which are more common. As an example, Artemis said, "There aren't any services set up to deal with emotional abuse by caregivers or parental abuse [of adult children]. These are not seen as issues." Newly funded government programs, such as the new Manitoba Community-Based Second Stage Program, focus on partner abuse, which may not be as relevant to some women with disabilities. Helios asked, "What's the good of services for abuse by boyfriends or husbands? Most of us don't have any." It should be noted that there were assurances made by people at a management level that these programs would try and meet the needs of women with disabilities facing other types of abuse. The policy

is to be accessible with regard to a wide range of needs, but reality may make this more difficult. For example, someone requiring a high level of personal attendant care may challenge current services, even if they have an accessibility policy.

Another potential source of support is agencies intended for people with disabilities. However, these agencies tend to lack knowledge of abuse and how to assist. Both Electryon and Iambe mentioned trying to get help from disability-based agencies. Electryon said, "I don't want to say where I went, but they really didn't know the first thing about abuse. They did try and understand how I was feeling, but they couldn't help me deal with it." Iambe noted that "The disability groups don't have connections to the police and counsellors, so they don't know where to tell you to go. They do, however, make you feel more comfortable about having a disability." Their lack of knowledge about the resources and procedures limits the degree to which disability organizations can become involved in issues of abuse.

In order to be effective for women with disabilities, social services need to increase the knowledge, sensitivity and comfort of their workers regarding the issues of women with disabilities. Helios said, "I'm not going to ask for help if I feel they're not going to be sensitive to me as a disabled woman. Plus, they need to feel comfortable dealing with me." A number of the women in the study also called for the need for workers and counsellors with disabilities. Hecuba felt that "If the counsellor had a disability that would go a long way toward creating understanding and an equal

footing. But they also need to know about abuse." Finally, almost all of the women said that services need to let women with disabilities know that their programs are available and accessible, including information on how to access the services. This includes an acceptance of women for issues beyond battering or partner abuse.

Before leaving this section, I would like to comment further on the current situation. It should be noted that there is a continuum of accessibility of services, and those moving toward providing greater access should be commended. There are a number of initiatives in the community which are encouraging and exciting. Although many have not reached the goal of total accessibility, there are many organizations which are currently taking steps toward achieving greater access for women with disabilities, even in the time which has passed since the interviews were done.

In speaking with Marlene Bertrand, Director of Family Dispute Services for the Province of Manitoba, I was able to obtain an overall picture of the accessibility of services for abused women funded by the province. Aside from the services offered by each agency, the Family Dispute Services Branch provides a package on woman abuse in braille, audio cassette, and large print to funded agencies as well as to anyone else requesting this service. Ms. Bertrand noted that the area of accessibility was one in which they were attempting to gain awareness and sensitivity. In fact, she had just requested an accessibility survey of the province's ten shelters and four women's resource centres. Nine of the shelters and all four

women's resource centres had replied as of August 31, 1995.

Of the nine shelters that replied, six provided wheelchair access to varying degrees (Winnipeg's Osborne House, and the shelters in Portage, The Pas, Steinbach, Winkler, Selkirk, and Brandon); five provided TTY phones; four provided large print or audio cassettes for those with visual impairments; and two kept a list of sign language interpreters who could be made available upon request. The shelter in Portage could provide home service if necessary. As well, the shelter in Winkler has a community network of individuals who can assist those with disabilities and special needs. I also know that Osborne House in Winnipeg would try to make arrangements for attendant care services if they were required by a woman. The shelter in Thompson offers no services at the present time; the one in The Pas offers only wheelchair access; and Ikwe-Widdjiitiwin, the shelter for aboriginal women in Winnipeg, which also houses the toll-free provincial crisis line, has TTY service, but is not wheelchair accessible. Ms. Bertrand did note that it is the goal of the province to have total accessibility for all of the shelters.

Of the four women's resource centres in the province, two (in Winnipeg) are currently wheelchair accessible. One, North End Women's Centre, which became accessible only in the last year, will also provide home service if necessary. The other, Fort Garry Women's Resource Centre, also has TTY phones and sign language interpreters or attendants upon request. Pluri-Elles, the francophone centre in Winnipeg, should become wheelchair

accessible by November, 1995. The Northern Women's Resource Service in Flin Flon does not report wheelchair access, although it does provide home service if necessary, and provides large print materials, sign language interpretation, and audio taped material. The satellite office, in The Pas, is wheelchair accessible.

The case for other community funded, counselling agencies in Winnipeg is not as positive. Of six agencies funded by Family Dispute Services, only two are wheelchair accessible and have TTY service, and one other provides TTY service. As well, the Second Stage Housing program is now in a wheelchair accessible location.

The efforts of those centres and services toward providing greater access should be commended. As the Family Dispute Services Branch has identified this as an area of priority, I am hopeful that within the next five to ten years, all of these services will be at least physically accessible to women with disabilities. At the same time, they will need to make greater efforts at outreach in the disabled women's community in order to ensure that women with disabilities feel that these agencies are in fact open, accessible, and welcoming to them. In addition, the work of disability-based agencies such as the ILRC in increasing consumer awareness of available and accessible abuse services is extremely important and must continue.

6.6.2 MEDICAL AND MENTAL HEALTH SERVICE SYSTEM

As noted earlier, questions were not asked specifically about the medical and mental health service system. Therefore, the following is information gleaned from general comments about

community resources.

In the case of people with disabilities, the most appropriate resources, even for dealing with abuse, are seen to be medical practitioners utilizing medical interventions. Among community service providers working in the area of abuse, only medical personnel are seen to have the expertise necessary to deal with people with disabilities. It is as if the disability overrides all other considerations, including the specialized field of dealing adequately with the effects of abuse. However, it has been shown in other settings that it does matter how a skull fracture was obtained; it matters whether or not it happened as a result of the abuse. It should matter less who the victim was. Who the victim is should not be the determinant of resources in this case. Treating the effects of abuse means more than just treating the physical signs of it. Artemis said, "We need to have people help mend our minds and souls--not just our bones." Women with disabilities are not given access to more appropriate abuse resources because service providers, being uncomfortable regarding disabilities (due to a lack of awareness), feel they lack the expertise to deal with these women, whereas what the women need is someone who understands the dynamics of abuse, regardless of the characteristics of the victim. Their uncertainty of their expertise is sometimes fed by medical professionals who work to maintain their dominance in the lives of women with disabilities. Amphitryon, for example, said, "A counsellor once told me that doctors had told her in the past that abuse was more of a medical concern, which needed to be properly

treated. She was told this was because of the complexities involved in a disability."

A number of the women in the study referred to medical and mental health professionals and their propensity to scratch only the surface or to mask the abuse problems being experienced by women with disabilities. Helios, for example, said, "My psychiatrist never had the time or desire to talk with me about what happened. It was easier to write another prescription." She added, "It is hard to find a doctor who goes beyond drugs to provide the real help many women with disabilities call for." Tranquilizers are often used as an alternative to the counselling seen as important by many women with disabilities.

6.6.3 LEGAL SYSTEM

Again, more questions could have been asked to be able to gain more data specifically on the legal system.

The legal system, including the police and the courts, is not viewed by several of the women in my study as being supportive of women with disabilities. For example, Erinna said, "Going to the police was worse than being raped because they didn't believe me or take me seriously. I know non-disabled women feel that way too, but I really think that my disability makes me even less credible." A number of women with disabilities in my study cite issues of lack of accessibility, lack of belief or credibility, and being discouraged (by family, friends, others who had been victimized, and in one case, by the police) from reporting as major barriers to their use of this system.

A dangerous situation is created in the event of a sexual assault or other offense occurring when the woman is not believed. Especially for women with mental or psychiatric disabilities, credibility can be questioned. Stereotypes and devaluation may lead to these issues of credibility. Several of the women felt that this happens either because no one would believe this could possibly be happening, as "women with disabilities are not sexual objects" (and are more likely to be the objects of pity than desire), or because people may believe that the woman with a disability should be grateful for any sexual attention. Additionally, some people may believe that due to impaired mental functioning, the accounts of women with mental or psychiatric disabilities may not be valid. Several women said that, "Police and lawyers are just as guilty as anyone in believing the myths about women with disabilities." Demeter's perpetrator said to her in surprise: "I thought you wouldn't mind." Ismene reported that some people felt that she was "lucky to have gotten any 'affection' at all." Also, due to the belief that women with disabilities are supposedly asexual, a number of the women in my study felt that they are <u>really</u> not viewed as credible witnesses in crimes of a sexual nature. Artemis said, "Women tend not to be believed. Women with disabilities are almost guaranteed not to be believed." After all, some of them think they are not seen by the police or others as possessing any knowledge in this area. We know of some recent successful prosecutions in cases involving women with disabilities, so perhaps this is changing.

Another aspect of being different is exemplified by Thetis'

experience of sexual assault. She was discouraged from reporting her assault or pressing charges because of her disability. Her psychiatrist firmly believed that no one would believe her because she had a psychiatric condition. She felt that he certainly did not believe her. "I see those roadblocks and barriers as abuse. Those things that are everywhere; they keep you from doing what others are entitled to. My psychiatrist said that I shouldn't press rape charges because no one, especially the police and judges, would believe a psychiatric patient anyway." The difference here made her a second class citizen who could be victimized with no legal recourse.

As can be seen, changes to educate people in the legal system and to increase the access to women with disabilities are necessary if women with disabilities are to feel supported by the legal system. Part of these changes rest upon a higher valuation of the credibility of women with disabilities. However, many of the difficulties are also shared by non-disabled women and are not all necessarily unique to women with disabilities.

6.6.4 INFORMAL SOCIAL SUPPORTS

As in the case for women generally, friends and family are viewed as a major source of social support. However, for a number of reasons, informal supports are limited in their ability to provide support and assistance to women with disabilities who have been abused.

Women with disabilities in my study described insular lives, being surrounded primarily by family, or by friends who tended also

to be disabled. Antigone reflected upon this by saying, "Growing up, I never really got out except to go to school...Now I have my family, who sometimes still abuses me, and my friends, who all have disabilities too."

The significance of this is that for a number of the women, these two potential sources of support may be quite minimal. Family may be part of the abuse and, therefore, not supportive. Or, friends may be in similar situations, or equally vulnerable, and therefore unable to provide much, if any, support. Electryon did mention this, as she said, "Helios and I are friends. But when it comes to us having rough times, we can't help each other. It's hard to deal with all of our stuff at once." They saw their peers as too powerless to help them. Ironically, their peers are probably the most likely to understand them.

Therefore, the women may need to search out alternate sources of support. This could include self-help groups, the development of friendships with non-disabled women, linkages with the women's community, and other broader relationships. This is not different from non-disabled women.

Although it is important to consider that these women's experiences take place in a patriarchal society, most of the women are unaware of this fact. Perhaps the only exception to this would be Artemis, who had connections to the feminist community prior to the acquisition of her disability. This, in itself, is significant. The women are largely unaware of this reality, and patriarchy is more

powerful when it is insidious. That is, when unchallenged, it is accepted as the way things are. Patriarchy defines male power and perogatives. Berger and Luckmann (1966:109) do note that "He who has the bigger stick has the better chance of imposing his definitions of reality." Those with the bigger sticks in our society are the white, Anglo-Saxon, wealthy, able-bodied males. They have an inordinately large role in the creation and maintenance of reality. Most of the women in my study saw the power of most women with disabilities as limited. This, they felt, translated into being viewed as good victims of abuse.

Another factor is the ableist nature of society. Attitudes toward women with disabilities are not neutral. They are negative, and, in some cases, openly hurtful. This feature influences all micro level interactions which occur in our society. None of the women in the study identified this larger level influence, concentrating instead on those individual interactions. Again, this may be due to the hidden nature of prejudice, but it may also be that for the women to acknowledge this dimension would mean accepting an overwhelming and hurtful reality. Such an assessment would make these troubles less individualized, as the women could see that these attitudes influence all people with disabilities.

Our societal reliance on medical authority has also led to the medicalization and individualization of social problems. This leads one to believe that problems are located within an individual, and if individual circumstances were manipulated, this would lead to change. This view limits us from seeing larger societal forces such

as capitalism and patriarchy as problematic and in need of change. As the individual is the easiest point of intervention, this also leads to a victim-blaming mentality, about which a number of the women spoke. They acknowledged that victims tended to be blamed for the abuse, but saw no realistic options.

These structural conditions lead to the conceptualization of problems as being individually based. Therefore, women with disabilities, rather than seeing the problem as being "out there," come to define themselves as being "easy prey." The solution, then, would be for them to be protected from danger. However, this type of approach shields the dominant structural elements, such as ableism and patriarchy, from public scrutiny or efforts at change.

The interventions (especially the formal ones) were intended primarily to address patriarchy. The response system was developed with the perception of homogeneity of women--that all women are the same (i.e., white, middle-class, able-bodied). Does this leave out women who have different needs, inherent in different religions, cultures, abilities, etc.? Other groups have moved, for example, to set up separate social services and shelters, such as in the Aboriginal, immigrant and Francophone communities.

The experiences of women with disabilities occur within the context of a patriarchal and ableist society. We are led to wonder if interventions in the generic services are able to address the problem for women with disabilities. Therefore, they might remain largely ineffectual in modifying the impacts for women with disabilities because they are only addressing <u>part</u> of the problem.

As can be seen, Figure Two (p. 171) provides a framework for beginning to systematize our understanding of the experiences of abuse as related by women with disabilities. Comparing Figures One (p. 73) and Two enables us to find the areas of overlap and of difference for women who are non-disabled and those who have disabilities. Based on the data from the women in my study, it appears that there are a number of points of similarity and of difference. However, since the framework was developed after the data collection, I cannot conclude that their experiences are the same. Future research needs to ask specifically about each of these elements in order to determine whether or not this is the case. Since questions were not asked directly about each of the areas, some women did not offer insight in those areas, and if they had, a very different picture may have resulted.

CHAPTER SEVEN: CONCLUSIONS AND RECOMMENDATIONS

7.1 THE PROBLEM

As noted, violence against women has not been that widely studied. Additionally, the specific experiences of violence among women with disabilities has been subject to even less scrutiny. This, in part, is due to a lack of attention to the needs and experiences of women with disabilities more generally. It is also perhaps due to a naive belief that women with disabilities are not the victims of abuse and violence, particularly abuse of a sexual nature.

In this exploratory study, I extracted a conceptual model from the literature, and then used the interviews to gauge the relevance of the model to women with disabilities. This is an important first step in attempting to systematize our understanding of the experiences of abuse among women with disabilities.

7.2 OVERVIEW OF THE LITERATURE

The literature provided a baseline context for the research and pointed to areas of knowledge and gaps. Studies suggest that the risk of abuse for people with disabilities is 1.5 to 2.0 times greater than for their able-bodied peers (Sobsey, 1988; Doucette, 1986). It was noted that women with disabilities face vulnerability both as women and because of their disabilities.

Reasons for the higher vulnerability were explored. These include lower self-esteem, fewer societal controls on abuse,

biological differences, negative attitudes, myths, and lack of accessible services, among others. As these were more closely examined, the social bases of vulnerability became increasingly evident.

Oliver (1983) argues that it is the handicapping effects of a society geared to an able-bodied norm that "disables" far more than any actual biological impairments. He argues that disablement is socially constructed and the experiences of disability can be viewed as an example of social oppression and discrimination. This oppression and discrimination is related to an ableist bias in our society.

It was anticipated that a significant factor in the experiences of the women would be the distinction of early versus late onset disability. Therefore this aspect was also reviewed in the literature. There are some differences among the women in this sample. Many of these differences are related to other relevant factors, such as the development of healthy self-esteem and identity. It was shown that low self-esteem is connected to the experience of abuse and violence, although the nature of that association is not as well known.

7.3 THE CONCEPTUAL FRAMEWORK

The conceptual framework developed in this thesis draws together some of the knowledge about the experience of abuse and violence. The framework, which has abuse and violence against women (with disabilities) as a central feature, not only presents the

major factors thought to be involved in abuse and violence, but also draws attention toward the dynamic relationship among variables. For example, interventions influence predisposing factors and impacts on the women, as well as directly or indirectly influencing the occurrence of abuse and violence. Impacts on the women may feed back on the predisposing factors or on the interventions. Predisposing factors also have important effects on impacts on women, as well as what effect interventions are likely to have. Depending on the constellation of predisposing factors affecting a particular woman, different interventions might be preferred. The framework sensitizes us to the fluid and interactive nature of variables associated with both able-bodied and disabled women's experiences of abuse and violence, and suggests that changes in one area may have ripple effects in other areas.

7.4 POSITIVE CONTRIBUTIONS

This framework facilitates an exploration of the abuse of women with disabilities in a conceptual comparison to the experience of women (i.e., non-disabled) generally. Such an approach acknowledges that the experience of women with disabilities may not be qualitatively different, but does have unique nuances.

Rather than continue treating the experiences of women with disabilities as separate and unique, use of the conceptual framework enables us to see the common nature of the women's experiences. Such an approach identifies the commonality and then explores areas of difference. Although there are differences, use of the conceptual

framework lets us see that there are more areas of similarity than difference.

There are, however, some factors associated with having a disability, which must be taken into account. This includes factors such as societal devaluation of persons with disabilities, accessibility requirements, different life experiences while growing up (such as separate schools), interactions with caregivers, dependencies on others, and visible vulnerabilities. This leads us to see that the increased risk of abuse and violence experienced by women with disabilities is more connected to how we as a society respond to people with disabilities than to physical or biological differences. An extension of this is that women with disabilities as "easy prey" is the result of systemic social conditions as opposed to purely individual vulnerability.

By having us consider the multifaceted dynamics of experiencing abuse and violence, use of the model assists us in developing a deeper appreciation for the complexity and diversity of women's experiences, while highlighting the commonality. Abuse and violence are deep, complex issues, which do not have easy solutions. My research points to a number of areas for future inquiry.

Finally, this research emphasizes the need to connect theory and practice. Although my study is not theoretically based, it points out the need for future research which is grounded in a theoretical body of knowledge.

7.5 MAJOR FINDINGS

The conceptual framework facilitated an in-depth examination of the experiences of women with disabilities in relation to the experiences of women generally. Although there are some nuances related to disability and violence/abuse, there are many similarities to the experiences of non-disabled women (as found conceptually in the literature). It would be important to let women with disabilities know that their experiences are not all that different. This may allow new alliances to be built within the women's community.

What are some of the major pieces of knowledge revealed by this study?

Definitions of Abuse

The most commonly reported type of abuse against women with disabilities in this study was verbal/emotional/psychological abuse. A great deal of this appears to the women to have been directed at their disabilities or limitations as a result of their disabilities. This points to the negative attitudes held about disability in our society. In my study, verbal/emotional/ psychological abuse was followed in decreasing frequency by adult sexual assault, physical abuse, childhood sexual abuse, neglect, and financial exploitation.

The women in the study described the different ways they came to see their experiences as being abuse. This included things like: knowing it wasn't right, seeing it in someone else's life, crossing a line in frequency or severity, education or the media, and

learning from professionals. Participating in the ILRC Abuse Survey was another aid to defining experiences as abuse. Most of the women realized that it was abuse only after some time had passed and they looked back on it. It was interesting that women with early onset disabilities were more likely to normalize abusive experiences, especially those which they could connect to their disabilities. As this was the only reality they knew, what they experienced was seen as normal, not abuse. In addition to the lack of comparison in their own lives, they also lacked the interactions with non-abused peers, etc. which might have cued them into seeing their experiences as abuse.

Although neither group of women possessed good clear knowledge of abuse, those with late onset disabilities were more likely to be able to separate what was due to abuse from how they were treated as a result of disability. Those with late onset disability also seemed slightly more likely to attribute some of their difficulties to the positions and power of women relative to men in this society. Many of the women still saw their experience as an individual one, but not necessarily as due only to disability. Where abuse only started after the onset of disability, these women were more likely to make a direct connection between the disability and the abuse.

Predisposing Factors

In terms of predisposing factors, women with disabilities shared a number of factors with women generally, but there were some points of departure. All of these factors worked to keep

women with disabilities in, or from leaving, abusive situations.

Many of the women in this study grew up in abusive families of origin. Roughly half of them were still connected to abusive families. In addition to the economic dependency faced by women generally, women with disabilities also talked about dependency on agencies of the state, such as welfare and homecare, and dependency on people--often necessitated by actual physical or mental impairments.

The love bond, for partners, was in existence for women with disabilities, although not many women with disabilities in my study had intimate partners. The love bond was more of a factor in relation to a commitment to families, especially parents. The fear of loss of children was more related to the lack of encouragement and opportunities for women with disabilities to have or keep children, than to experiences of abuse. They were, however, made to feel overly responsible for the family and whether or not the family stayed together or was able to pursue opportunities.

Isolation, related to having a disability and from experiencing abuse, was a major factor in predisposing women with disabilities to abuse. Women with disabilities also feared further personal harm or retaliation from the abuser, as well as fearing for the safety of others, such as mothers, children, or friends. Unlike women generally, they did not mention worrying about the safety of their abusers.

Many of the women with disabilities felt they had nowhere to go, and no one to talk to, particularly because they felt people would

not understand their unique needs as women with disabilities. The fear of losing assistance and services, such as attendant care or transportation, was another very salient factor. Finally, stereotypes and beliefs about disability, along with a number of disability-related factors, were seen as important in terms of keeping women with disabilities in, or escaping from, abusive situations.

Impacts of the Abuse

Before reviewing the impacts of abuse revealed by the women with disabilities in this study, I should reiterate that women found it difficult to sort out the respective contributions of disability-related devaluation (which many defined as abusive) and other kinds of abuse. For example, women in the study felt that their self-esteem was very low just as a result of having a disability.

Women with disabilities suffered physical and psychological problems, such as physical trauma, sexually transmitted diseases, sleep disturbances, depression and dissociation, self-harm and suicidal tendencies, and substance abuse. They also noted that abuse sometimes causes or exacerbates disabilities and this causes even greater emotional turmoil. Loss of self-esteem was the most consistently noted effect of abuse on women with disabilities. Some noted that this effect was of an even greater magnitude due to the already low self-esteem of many women with disabilities. Women with disabilities in this study also felt a combination of shame, humiliation and self-blame, resulting in feelings of hopelessness and helplessness.

It was also important to discover that abuse led to an increased amount of isolation and dependency for women with disabilities, who were already feeling isolated and dependent. Finally, the women reported the impact of damaged or destroyed trust, particularly because much of the abuse was at the hands of people in positions of trust.

Another reaction to the abuse was denial. Abuse was denied to be happening not only by the women, but also by others, including the perpetrators. A great many of the reasons or alternate rationales were related to having a disability or being around someone with a disability. This was described by some as being a burden, or "understandable" as reactions to stress and frustration.

Another aspect of denying abuse was to place the blame on disability. This included women with disabilities perceiving themselves as "easy prey." Blaming disability could be related to isolation and lack of knowledge, as those who had contact with non-disabled peers were less likely to blame their disabilities for the abuse.

Finally, a number of the women talked about being unable to identify or pursue non-abusive relationships. Much of this inability was seen as related to having a disability, such as the normalizing of experiences and relationships, the push to be "normal," and the perception that anything, including abuse, is "better than nothing."

Interventions

The last area to consider is interventions. It was noted that in order for interventions to be successful, they need to be responsive

to women with disabilities, and women with disabilities need to know that they are available, accessible, and effective in terms of their disability-related needs.

In this thesis, I introduced the idea of a continuum of accessibility of services. Although the situation is improving, there is still a lack of totally accessible social services in Winnipeg. Even more important might be that women with disabilities believe there to be even less access. Women with disabilities in the study talked not only of the lack of physical access, but also of attitudinal barriers to service. The need for a broader mandate, beyond partner abuse, was also noted. They also saw the need to educate service providers about the needs and lives of women with disabilities. It was also suggested that having workers or counsellors with disabilities would also be very helpful, particularly in letting women with disabilities know that a service would be accommodating to them. Additionally, some work could be done to educate disability-related organizations about abuse and how to deal with it. Initiatives such as those at the ILRC could be expanded to help with this task.

Despite the current reliance on medically-based services, women with disabilities said they wanted less use of medical services. They said that they were not as appropriate as generic abuse-related community resources, like shelters, crisis lines and counselling services, and tended to lack the time and expertise in counselling. They felt that medical resources relied on medical solutions such as tranquilizers or fixing broken bones, which

although important, only masked some of the psychological problems.

The legal system was noted as insufficient because women with disabilities were seen as lacking credibility--beyond that experienced by many women generally. People in the legal and police systems need educating about disability awareness. Women with disabilities were also discouraged by other people with disabilities, as well as family and friends, from reporting abuse, which means that many experiences don't even make it into the system. There was also some self-censoring, wherein because they believe they will not be believed by the police, some women choose not to report incidents of abuse and violence.

Finally, interventions and support by family and friends are limited. This is because often family members may themselves be perpetrators, or lack information and resources to help, and friends are often viewed as being in similarly vulnerable circumstances. This points to the need for other sources of informal support, such as peer support and self-help groups.

7.6 RECOMMENDATIONS

In addition to these findings, there are a number of specific implications or recommendations suggested by this research and by the women themselves in the course of the interviews.

There is an overall need for greater valuation of the lives of people with disabilities. This implies an overall respect for differences of all types. Until this happens, the lives of people with

disabilities will be judged negatively, and will therefore be connected to predispositions to abuse. This will also affect potential interventions. This would also lead to greater self-esteem for many women with disabilities, impacting on their ability to respond to abusive situations in their lives.

Steps need to be taken to decrease the isolation of women with disabilities, and to facilitate access to positive and realistic role models for people with disabilities.

An overall goal or plan for action involves the need for increased and full inclusion of women with disabilities in the feminist movement, which would also facilitate greater understanding and the lessening of perceived differences between the groups. There is room for collaborations to work together in finding solutions for abuse and violence.

1. Work should be done to expand initiatives such as the ILRC Abuse Advisory Committee, which includes representation from generic services. A concrete step by the group would be the creation and widespread distribution of a brochure which outlines the continuum of accessible services.

2. The research suggests the development of a multi-level educational program aimed at both the public and women with disabilities. Education should also be given to caregivers and other professionals in the area. Education should be aimed at destroying myths and fostering new understandings and ideas related to the independent living philosophy, because the myths perpetuate a lack

of recognition and action. There should also be education directly about abuse. For people with disabilities, this would include recognizing ("naming" as the first step in finding solutions) and dealing with abuse. For others, it would include the fact that people with disabilities *are* the victims of abuse, and what to do about it.

3. Greater empowerment of women with disabilities is needed. This would involve people with disabilities having greater control and independence in the services and systems in their lives. It would include a greater balance of power between care providers, professionals, and women with disabilities. Therefore, I recommend that shelters and social service agencies be encouraged to have women with disabilities on their boards to ensure that policies and issues are not overlooked. Continuing and expanding the recent move in this province to a system of self-managed attendant care would also be a move in the right direction.

4. Women with disabilities need to become more involved in the disability movement. Men with disabilities must be made to recognize and include the separate and important issues for women with disabilities, such as abuse, mothering, body image, etc. A series of meetings should be held to foster these discussions and to begin to develop female leadership. Community disability organizations should develop affirmative action policies for women, in the way that disability is considered a critical factor. Organizations should be encouraging women to achieve strategic positions within the disability movement. There has been some movement to include women with disabilities on the boards of

directors of these organization; they may need to achieve a "critical mass" before they feel they can make meaningful contributions.

5. Community services providing counselling, shelter, and other responses to abuse, must be available and accessible, and provide the supports necessary to overcome any limitations imposed by disability. Women with disabilities should be included as advisors and as staff in these community services. Additionally, services should be required to advertise whatever degree of accessibility they possess. This would include doing outreach within the community of women with disabilities to let them know of the available services.

6. There also needs to be less authority and reliance on medical systems and services for people with disabilities. They should be entitled to a full range of options in services. Related to abuse, this would include increased access to services such as feminist counselling for those who have experienced abuse. This may mean the need to train and support those generic services to feel confident in serving women with disabilities. Training should also aim to prevent the automatic assumption that the appropriate service for women with disabilities must be medical.

7. Support and caregiving services need to be available and accessible, and offer a range of options and choices, in the individual's own home and in the community. That way, they are not forced to rely on abusive services for lack of choice. This calls for the need to consult with women with disabilities in setting up services, and to continue to offer self-managed care options.

8. People within the legal system, such as the police, lawyers, judges, etc., need to become sensitive to the needs and realities of women with disabilities. Women with disabilities also need to be aware of any measures that are taken, including an increased awareness of the necessity of reporting. Concrete measures to achieve this include awareness training for those in the legal system, and education for women with disabilities. Additionally, the province should make available a legal advocate, who is sensitive and competent in areas of disability and the law, who could be accessed by the police and by disability organizations.

9. Setting up opportunities for peer support would also lead to another source of informal support for women with disabilities. I recommend that peer support opportunities be made available by both disability organizations and women's organizations, so that women can choose. Groups could also work together to facilitate a "mixed" group. Advertising of the groups should be done in both the women's and disability networks.

10. The federal and provincial governments must support local initiatives by providing the support and resources necessary to make services accessible. In addition, provincial and federal listings of services in the area should list the accessibility of services.

7.7 LIMITATIONS OF THE STUDY AND RELATED RECOMMENDATIONS

The generalizability of the study findings is limited by a number of factors. First, a relatively small number of women with disabilities was interviewed. A wider scope would have resulted in a sample reflecting greater diversity of experience in terms of age, ethnicity, rural vs. urban differences, disability, etc. A second factor is the non-random selection of study participants. Participants were self-selected following completion of the ILRC abuse survey. Third, all of the women interviewed were somehow connected to the ILRC, which may have introduced a selection bias. Individuals connected to the ILRC may be more confident, independent, etc. Finally, there may have been bias due to the nature of self-selection. Individuals who agreed to participate may or may not have differed in certain ways from those who did not participate. It is impossible to determine what those differences might be. There was also a lack of comparison to other groups, such as non-disabled women and disabled men, which limits the statements which can be made.

The difficulty of the topic must also be considered. Abuse is a difficult topic to talk about openly. Although efforts were made to ensure safety and a level of comfort, there was still an unspoken discomfort, perhaps that of shame, or difficulty in exposing old wounds. This was reflected in the relatively brief comments and descriptions made by the women. Comments tended not to be

lengthy. Of course, this could also be due to the level of interviewer skill or the need for further probing questions. It could also be that the nature of the topic necessitated building a trust relationship with the interviewer over time, which was not done with these one-time interviews. If I had done subsequent interviews, I would have been able to ascertain more about the women's histories over time, and I would have gained greater insights into their experiences. I think I might have been able to ask more personal or challenging questions as I got to know them and they felt more safe and comfortable with me.

The research was also not as feminist informed as it could have been. It was a woman-centered study, but not directly praxis-oriented. Ideally, theory would have been used as a guide in framing the interview questions, which would have ensured that data was available for all the areas of inquiry (i.e., all components of the conceptual framework). However, the data was collected for the purposes of exploring the prevalence of the problem of abuse as well as for gaining some insight into the role of the ILRC. As the data was collected for purposes other than this thesis, it was not as much guided by the literature and theoretical foundations as it might otherwise have been. For example, as noted, theory could have been used to form interview questions as well as to suggest use of an action research model. Although it came from women, the data did not focus on the gendered nature of either disability or abuse. Subsequent studies should focus directly on gender and ask questions more directed at gaining perspectives on their experiences

as women, about perceived power relationships. This would provide a more thorough understanding of how gender identity, relations and politics influence individuals' experiences of disability and abuse. As well, with research involving both men and women, such an approach would also permit a more careful and meaningful comparison of the experiences of disability and abuse among men and women.

It would also be useful to somehow isolate the relative impacts of early abuse and of early differences in socialization. This would enable us to examine the relative impacts of abuse and of disability. One way to do this might be to compare to the experiences of non-abused women with disabilities and to look for differences and similarities, for example in self-esteem.

It would also be beneficial to ask more specific questions on the elements included in the conceptual framework. As I noted earlier, I did the study and then developed the model. Following this, I then tried to mould my data to the model and the fit wasn't always the best. This left gaps which would need to be addressed in future work. This would include asking questions specifically about conceptualizations of easy prey, so that we could deepen our understanding of the dynamics involved. It should also involve asking more direct questions about early socialization and early experiences with disability, information about family of origin, as well as about their perceptions of other people's attitudes, etc.

A key feature of some feminist research practice is the validation of findings by the participants themselves. In this, and

future research, the women should be consulted to see if the portrayals and findings are valid to them. This is not only important as a validating tool, but also enables individual women to learn from the research implications. Therefore, I would suggest that a form of participatory action research be used in future research endeavors in this area.

7.8 CONCLUSION

"Easy prey" challenges the idea that women with disabilities can have full, independent lives. Abuse puts barriers in the path of independence. As a societal creation, "easy prey" can and must be changed.

Independent living philosophy is helping people with disabilities create new possibilities in self-direction and control. It is a philosophy which empowers people with disabilities and which at its extension, will lead to greater confidence and self-esteem for women with disabilities. Hopefully, this will lead to a rejection of the "better than nothing" thinking which was so prevalent among the women in this study.

I believe that we can and will make the changes needed to reduce the incidence of abuse in the lives of women with disabilities. However, it will require a multifaceted approach, involving cooperation among women with disabilities, the women's movement, and the disability movement. The problem will require education of the women and of wider society, as well as direct intervention aimed at the predisposing factors and impacts of abuse

and violence.

There is the need for changes at a very basic level to the way people with disabilities are valued in our society. Until widespread devaluation is eradicated, problems of abuse of people with disabilities will continue. Women with disabilities are subject to double devaluation, or "double jeopardy," and the roots of this devaluation must be addressed. This requires that challenges be made to both patriarchy and ableist systems and attitudes. Such change is not simple or easy. It will take a great deal of time and energy. However, there is no time like the present to begin.

APPENDIX A

- Definitions of Abuse

DEFINITIONS UTILIZED IN THE COURSE OF THE ABUSE AND DISABILITY PROJECT AT THE INDEPENDENT LIVING RESOURCE CENTRE, WINNIPEG, 1993:

The following, including specific examples in order to increase clarity, have been utilized in defining abuse at various times (i.e., in simpler form in the survey; also used in final reports with contributions from results, etc.) in the work in Winnipeg:

1. **Physical Abuse** *is any non-accidental harm or injury inflicted on a person. This includes ongoing and deliberate things done to a person (or the threat of these), such as rough handling, slapping, shoving, pinching, kicking, restricting movement, hitting, choking, beating, burning, or items being thrown at the person.* This type of abuse is often the most obvious, but can vary greatly in degree of severity.

2. Verbal/Emotional/Psychological Abuse *refers to such things as insulting someone, using profane language (swearing), humiliating a person, intimidation, threats, harassment, coercion, treating an adult like a child, yelling, and using language or actions to degrade someone, or other things intended to made a person feel bad about who they are (including their disability).* This type of abuse often occurs in conjunction with the other types, but may occur independently.

3. Sexual Abuse is involving a person in a sexual act without the person's consent. This was broken down into child sexual abuse and sexual abuse/assault as an adult. **Sexual abuse as a child** (age less than 18 years) included *any [unwanted] sexual activity experienced as a child, including forced undressing, fondling, masturbation, intercourse, rape, being made to look at (i.e., exposure/flashing) or touch genitals, inappropriate sexual remarks or connotations, exposed to or involved in pornography, being sexualized (i.e., watched or talked to in a sexual way).* **Sexual abuse/assault as an adult** meant *any sexual activity which was not consensual, sexual activity against the person's will, including rape, unwanted touch, forced penetration (including with objects), sexual violence, sexual harassment, invasion of privacy and boundaries (either psychologically or physically), obscene phone calls, forced to watch or participate in*

pornography, forced prostitution, encounters with flashers (people exposing their genitals), the use of threats aimed at getting a person to engage in a sexual activity, etc. Sexual abuse can also include manual, oral, anal, genital, buttock or breast contact or the use of objects for sexual penetration, fondling or stimulation.

4. Financial/Material Exploitation/Abuse *is taking money or other materials things (i.e., things a person owns, such as jewelry, t.v., clothes, etc.) from a person without their permission. This could involve stealing, withholding of money, forced changes of wills, misuse of power of attorney, doing things to trick or cheat a person out of money/items, controlling all the money without consent, insisting on person accounting for each and every penny, badgering or threatening a person to given them money, embezzlement, etc.*

5. Neglect *consists of refusal or failure to provide the basic needs such as adequate heat, food, clothing, clean conditions, exercise, shelter, affection, withholding medications or treatments, not allowing to go to the bathroom, abandonment, etc..* It includes things actively done or those which occur due to omission. Neglect can be physical, medical, emotional, or neglect in terms of failure to educate regarding having rights, independent living, etc.

6. Professional Abuse *are things done by a professional which are hurtful or cross the bounds of "professional ethics." This could include a professional who has committed any type of abuse (i.e., physical, emotional/verbal, sexual, neglect, financial, etc.), or has done things without informed consent, subjecting individuals to unexplained tests or procedures, breaking confidentiality, not taking concerns seriously (invalidating or minimizing), intimidation, threats, accusing of wasting government funds or resources ("not worth it"), etc.*

APPENDIX B

- ILRC Abuse Project Objectives and Activities

ILRC ABUSE PROJECT OBJECTIVES AND ACTIVITIES:

1) To carry out a thorough search and summary analysis of the literature in the area of abuse and disability. This literature review will try and focus on the area of intersection rather than try and explore the larger areas of abuse and of disability in the literature. The review also included mostly Canadian material, although some American and British information was included.

2) To design and conduct a needs assessment exploring abuse in the Winnipeg disabled community. Examination of the nature of abuse experienced, as well as its effects, and the barriers to healing, will take precedence over trying to establish incidence rates. This assessment will also attempt to explore the unique vulnerabilities of persons with disabilities in experience and dealing with abuse, particularly those individuals who are highly dependent on those around them.

3) To continue to develop, consult with, and support the Abuse Advisory Committee which provides direction and advice to the project. This Committee was a cross-representational committee made up of consumers, people providing services to people having experienced abuse, people providing disability-related services, academics, and other interested community members.

4) To implement a plan for ILRC staff training in order to provide support to individual consumers who have or are experiencing abuse. This included both community resource awareness (generally, and in terms of accessibility) and sensitization to issues of abuse.

5) To initiate a networking process with the service provider community, with regards to the issues of abuse and people with disabilities, in order to:

a) Work with existing community resources that have been assessed regarding their degree of physical/attitudinal accessibility and facilitate addressing these needs (i.e., work to try and improve community accessibility).

b) Examine the experiences, if any, of community service providers with people with disabilities and learn from those experiences.

c) Discover the educational needs of community service providers, specifically in the area of disability awareness, and work together to develop tailored educational sessions to each group.

d) Develop and provide, using consumers as educators, a training package for community service providers which would respond to their specific needs.

e) Identify other barriers to the provision of safe and helpful service to men and women with disabilities (e.g., finances, staffing, etc.).

f) Encourage the recruitment of people with disabilities as members of the advisory committees and boards of these service-providing organizations.

6) To establish a peer support mechanism that will provide interim support for people with disabilities in dealing with experiences of abuse. The experiences of women with disabilities and a peer support group on abuse are described in Andreychuk (1993).

APPENDIX C

- Letter for Interviews

INDEPENDENT
LIVING
RESOURCE
CENTRE

INDEPENDENT LIVING RESOURCE CENTRE
ABUSE RESEARCH PROJECT
INITIAL LETTER OF INTRODUCTION

April 1993

Re: ILRC Abuse Project
Personal Interview

Thank-you for agreeing to participate in a personal interview as part of the Independent Living Resource Centre's research project on Abuse and People with Disabilities.

I have not yet had a chance to schedule all of the interviews. This letter is to let you know that I will still be calling you in the near future to set up an interview time and location. If you prefer, you can phone me at 947-0194 to arrange a time for the interview.

You might wish to take some time to consider the following issues which might be covered in the interview:

- types of abuse encountered
- how do things come to be defined as abuse
- why abuse occurs, causes, myths
- disclosures of abuse - what is helpful, what is not
- effects of abuse on the person
- barriers to accessing services
- relation between abuse and disability; e.g., vulnerability
- possible topics for presentations or Independent Living Skills Workshops on Abuse.

Please note that if you have not personally experienced abuse in your life, I will be asking about your perceptions of these issues.

Once again, thank-you in advance for your participation.

Sincerely.

Teresa Andreychuk
ILRC Abuse Research Coordinator

201-294 Portage Avenue
Winnipeg, Manitoba
R3C 0B9
(204) 947-0194/TDD
Fax: (204) 942-3146
Toll Free: 1-800-663-3043

APPENDIX D

- Interview Guide

ILRC - INTERVIEW QUESTIONS FOR THOSE WITH EXPERIENCE WITH ABUSE:

Note: * - refers to those questions utilized in the thesis analysis.

- purpose of interview; length (try < 1 hr); any questions, etc.
  - to gain more detailed information on abuse, not to provide ongoing therapy
  - review consent form, check if o.k. to tape (for note-taking only)
  - check if they have personally experienced abuse - or ask the questions in a manner about their impressions of the various aspects reflected by the questions.

1. What are your expectations of this interview? [i.e., why are you wanting to do this interview?][not therapy or counselling].

2. Was there anything you were needing or wanting in doing this? [i.e., do this as a step in healing, etc].

*3. Could you tell me a bit about yourself? i.e., age, gender, marital status, living situation, disability, limitations, etc.

EXPERIENCES

*4. Could you briefly tell me about your experience(s) with abuse?

- types of abuse experienced
- what happened, circumstances
- could anything have been done to change what happened?

*5 How was it that you came to define this as abuse, assault, etc.?

*6. What effects did the abuse have on you at the time? How do you feel the abuse impacts on you today (if different)?

HELP-SEEKING

*7. Were you able to tell someone about the abuse? When and what were the circumstances around your disclosure of abuse? [if they did tell someone]

- useful, not useful responses
- reasons for not disclosing

*8. Were you able to get help or heal?

- explore helping/coping strategies
- barriers to help
- did disability affect help-seeking
- do you feel like you are healed/better, or continuing?

*9. What would have made things easier for you in dealing with the abuse? What do you feel is needed [in the disabled community, professional community, community resources, family, etc.]?

ABUSE AND DISABILITY

*10. What was the effect of the abuse on your disability, or the impact of your disability on the experience of abuse -- if any?

- did your disability change as a result?
- disability make you more vulnerable?

*11. Do you think that people with disabilities are more or less likely to be abused than those who are not disabled? Why? What about differences between men and women with disabilities? Why?

12. Are you aware of other individuals with a disability who have experienced abuse in their lives? Has this had any effect on you? or on them?

13. What do you think causes abuse or violence [including common myths about why people are abused]? Is there anything we can do to prevent it? What can we do about abuse?

14. Are there any topics or abuse/violence organizations you would like to learn more about, through presentations or I.L. Skills Workshops? Suggested roles for the ILRC, etc.

15. Is there anything else you would like to share/say?

Thank-you for sharing your time and your thoughts.

APPENDIX E

- Consent Form

INDEPENDENT
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INDEPENDENT LIVING RESOURCE CENTRE

ABUSE RESEARCH PROJECT

CONSENT FORM

Independent Living Resource Centre
Winnipeg, Manitoba R3C 0B9
(204) 947-0194

The Independent Living Resource Centre, with advice and guidance from the ILRC Abuse Advisory Committee, is exploring the area of abuse as it affects people with disabilities. One way of gaining information is the use of personal interviews in order to ask questions about experiences with abuse, effects, coping/help-seeking, barriers, and input about what might be done to begin improving community responses. This interview is part of a larger project examining abuse and disability in Winnipeg.

Interviews will take approximately one hour. They will be held at a place of your choice which provides the greatest degree of safety possible. All answers from the face-to-face interviews will be kept confidential. The information will only be viewed by the interviewer (Teresa Andreychuk or Rod Lauder), the project coordinator (Teresa Andreychuk), and where necessary, one person employed to do data entry (demographics would be removed). Steps, such as coding personal respondent information will be employed in order to ensure that your identity cannot be discovered.

We would like to tape the interviews. These tapes will be used to supplement interviewer notes in a written transcription. After transcription, the tapes will be destroyed.

201-294 Portage Avenue
Winnipeg, Manitoba
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(204) 947-0194 / TDD
Fax: (204) 942-3146
Toll Free: 1-800-663-3043

Information from the interviews will be compiled and summarized for use in the larger abuse research project. Interview information will be utilized in research papers on abuse and disability in Winnipeg. Individual identities will not be revealed in these reports or papers.

Please only answer the questions, or parts of questions, which you feel comfortable in answering. Your participation in no way affects your access to membership or services at the ILRC. We would also like to be able to approach you again in the future if that becomes necessary in order to gather more information or to clarify some information.

Any questions, concerns or comments can be directed to Maureen Colgan, ILRC Senior Project Coordinator at the above address and phone number.

Sincerely,

Teresa Andreychuk
Abuse Research
Project Coordinator

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