A Critical Inquiry into Social Workers' Perspectives, Theories, Models and Practice

Contexts Related to Disabled Women Who Have Experienced Male Partner Violence

by

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Abstract

Even though social work research on violence against women has increased in the last decade (Slayter, 2009), there is little research on social workers' understanding of disabled women's experiences of male partner violence (MPV). When there is a gap in research and practice evidence, this may lead to less than ideal work experiences because social workers may be lacking crucial information, to deliver meaningful support and assistance to disabled women. Given these findings, it was essential to hear from social workers who had worked with disabled women who had experienced MPV. The aim of this investigation was to inquire about social workers' perspectives, theoretical approaches and practice contexts related to disabled women who had experienced MPV. In this collective case study, sources of data that were accessed included federal and provincial government legislation, position documents, provincial archives, academic literature and thematic analysis of ten transcribed interviews of key participants. Findings showed that even though provincial government policies or programs were the main influences on social workers' practices with disabled women who had experienced MPV, work settings and social workers' attitudes also played a crucial role in how participants understood disability and male partner violence. Social workers in this current study often found themselves in the middle, trying to respect service users by meeting their needs, while remaining accountable to a system that demanded efficiency and accountability. Social workers often advocated for disabled women because of barriers such as a lack of accessible housing, transportation or work. Factors such as social welfare policies, social work education and training that shaped social workers' practices could be strengthened to help them to better meet the needs of disabled women who have experienced MPV.

Acknowledgments

"Truly powerful people have great humility. They do not try to impress, they do not try to be influential. They simply are. People are magnetically drawn to them. They are most often very silent and focused, aware of their core selves. ... They never persuade, nor do they use manipulation or aggressiveness to get their way. They listen. If there is anything they can offer to assist you, they offer it; if not, they are silent." by Sanaya Roman

"Power changes everything till it is difficult to say who are the heroes and who the villains." by Libba Bray

"The greatest enemy of knowledge is not knowledge it is

The illusion of knowledge." by Steven Hawking

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Chapter One – Introduction

Overview

  As I began this research, I learned that disabled women's experiences of male partner violence (MPV) were more complex when compared to non-disabled women (Copel, 2006; Hague, Thiara & Mullender, 2011b; Thiara, Hague, Bashall, Ellis, & Mullender 2012). However, there is no clear definition of disability or violence against women (DeKeseredy; Lundberg & Simonsen, 2016; Thiara, Hague, Bashall, Ellis, & Mullender). In my extensive readings and practice experience, I found that disabled women's male partners were often the perpetrators of violence against disabled women and disabled women could be more vulnerable to abuse than non-disabled women, if they were dependent on others, if they were socially isolated or poor (Copel; Nosek, Hughes, Taylor & Taylor, 2006; Powers et al., 2009). "There is also a distinct gender aspect involved…research undertaken in Western countries has [found] that women with disabilities experience social oppression and domestic violence as [a] consequence of the interconnections of gender and disability". (Lundberg & Simonsen, 2016, p.8)

  Furthermore, Thiara, Hague and Mullender's (2011b) study found that unless disabled women made explicit disclosures of abuse, professionals including social workers were not likely to recognize signs of partner abuse because they tended to focus on the impairment. "While [social workers] know domestic violence exists, they are less likely to believe it is happening to their clients. This may be due to lack of training regarding the prevalence of domestic violence and how to screen individuals for domestic violence" (Hefferman, Blythe, & Nicolson, 2014, p.705). In a different study, disabled women were often dismissed if they called authorities for help (Rich, 2014). One disabled woman said:

The officer came to the house . . . All he saw was a crazy woman in a chair and a normal healthy man. So there they were, two regular guys shooting the breeze, and there I was, a hysterical sobbing cripple in a wheelchair. He told the cop I was 'on the rag.' Furniture was knocked over—which of course I couldn't reach . . . Don looked good on the outside but he was nuts on the inside from a head injury . . .One day it finally occurred to me: 'He's broken, and I'm the healer'. (Rich, 2014, p. 424)

When disabled women found the courage to disclose partner abuse to social workers, participants reported being less than satisfied with their responses (Allen, 2013; Hague, Thiara & Mullender, 2011b). One disabled woman said that social workers wanted to send her to a completely inappropriate residential care home while, a disabled black woman remarked that social workers were not considering her cultural needs (Hague et al., 2011b). Disabled women in this same study said that social workers had failed to understand their needs as disabled women who had experienced MPV (Hague et al., 2011b). The respondents recommended that disabled women who report abuse should never be placed in a residential care home, as a result of male partner violence or be disbelieved; instead, they should be taken seriously by social workers and other professionals and receive appropriate assistance (Hague et al., 2011b). These particular disabled women's statements suggest that social workers "…need to give disabled women [who are] experiencing abuse, as much control as possible and to balance protection and risk assessment with a women's empowerment approach…" (Hague, Thiara, & Mullender 2011a, p. 163).

In order to mitigate disabled women's negative experiences with social welfare services, it is also essential to recognize that accessibility issues, the lack of resources and government cut backs also play a role in the restriction of social workers' practices (Galambos, 2004). For

instance, hospital social workers who were asked to facilitate discharges of disabled patients were faced with challenges because there was a lack of community services, not enough accessible housing and a long waiting list for next-level-of care, such as rehabilitation services (Redfern, Burton, Lonne & Seifert, 2015).

Although Taylor-Butts (2007) suggested that there are some Canadian women's shelters that are accessible to disabled women, Hague et al., (2011b) found that social workers who worked with disabled women who had experienced MPV, often had difficulty finding women's shelters that could accommodate them. Perhaps one reason for the lack of accessible shelters is that "there is now much evidence [to demonstrate] that social policy is contradictory…that at times it makes false assumptions about community and about personal and fiscal capacity to deliver key features of the policy agenda" (Roulstone, 2012, p.144). Roulstone is implying that policies are written in ways that give the impression that there is funding available for services, when in reality, there may not be enough capital and resources allocated to accessibility issues and women's shelters. Yet, government policies have a direct impact on disabled women who have experienced MPV (Olkin, 2003). Olkin stated that government policies determine who has access to social services and how much financial support they receive therefore, it is not enough for social workers to be supportive of disabled women because what needs to happen is that policies have to change to better meet the service users' requirements.

A similar argument was made by Westhues and Wharf (2012) on the role of the social worker in the delivery of social policy when they specified that social workers have some discretion in the way they interpret and administer social policies that affect service users. Westhues and Wharf suggested that a way forward, would be to understand how social workers interpret these social policies because their interpretations affect how they relate to service users

and often determine the course of their lives. For instance, if a disabled woman who is experiencing MPV is denied access to social services, she could end up staying in the abusive relationship longer.

On a different note, when it comes to social work practice, education, and training, it is important to acknowledge that social work has not always moved in tandem with disability scholars' perspectives (Roulstone, 2012). While the majority of social workers continue to gain insight into disability from social policy, medicine and law that generally *view disability* as an individual deficit or personal tragedy, a minority of social workers are beginning to develop a different perspective of disability, that is more in line with disability organizations that view disability as being located in the environment (Dunn, Hanes, Hardie, & McDonald, 2006; Oliver, Sapey, & Thomas, 2012; Roulstone).

Another issue identified by Slayter (2009) was that social work research on partner violence against women has increased in the last decade; however, at the time of this current inquiry, there was little research that was specific to social workers' perspectives and practice contexts related to disabled women's who have experienced MPV.

This current research focuses on social workers' understanding of disability and male partner violence and influences that affected their work with disabled women who had experienced MPV thereby, providing insight that was lacking in social work and disability literatures.

The purpose of the study

The aim of this investigation was to provide knowledge that would lead to a greater understanding of social workers' experiences and practice contexts in relation to disabled women who had experienced MPV. A glimpse into social work's historical background demonstrates

how today's social workers' practices with disabled women were shaped and how social workers have been perceived as both allies and gatekeepers by disabled women (Kim & Canda, 2006).

The main research questions for this investigation were:

- How do social workers understand and define disability?

- How do government legislation, policies and programs or agency policies affect how social workers work with disabled women who have been abused by their male partners?

- How do social workers understand and define male partner violence?

- How do social workers describe practice influences, barriers and experiences with disabled women who were abused by their male partners?

- What theories or models do social workers use when working with disabled women who have been abused by their male partners?

Social workers work in different settings such as healthcare, child and family services, women's shelters, private practices, schools and crisis shelters (Hefferman, Blythe, & Nicolson, 2014; Oliver, 2004; Oliver et al., 2012). For this reason, it was essential to interview social workers who were employed in various settings, to determine their perspectives and their experiences when they worked with disabled women who had experienced MPV. Insight into the social workers' practice contexts provided an additional layer to the analysis by "…enabling the researcher to answer "how" and "why" type questions…" (Baxter & Jack, 2008, p. 556). In this collective case study, sources of data that were accessed included federal and provincial government legislation, position documents, provincial archives, academic literature and thematic analysis of transcribed interviews, of key participants. These data were used to

determine how social worker participants understood disabled women's experiences of MPV and what influences were affecting these social workers' abilities to meet their needs.

Structure of the thesis

In the Second Chapter, 'The Literature Review', I present a brief historical overview of social work's background in relation to disabled people. I delineate the relative absence of disabled women's discourse in history, particularly, in social work and the impact that it may have had on social workers when working with disabled women. Put another way, when there is a gap in research or practice evidence, this may lead to less than ideal work experiences because social workers may be lacking crucial information, to deliver meaningful support and assistance to disabled women.

Particular attention is paid to the construction of disability and partner violence in the context of a dominant society (e.g., non-disabled patriarchal Western society) and how these definitions could have shaped disabled women's experiences and social workers' practices with disabled women. For instance, the Provincial Government's definitions of disability and partner violence, social workers' understanding of disability and partner violence, social workers' interpretation of federal or provincial policies and the availability of social services and resources could have facilitated or limited the assistance that social workers provided to disabled women who had experienced MPV.

In Chapter Three, 'Theories, Models and Approaches' I begin to provide a foundation for the theories and models that could be used by social workers in their work with disabled women who have experienced MPV and outline how some theoretical approaches could be viewed as oppressive.

In Chapter Four, 'Research Design and Procedures', I describe how a collective case study as drawn from Stake (2006) and other authors such as Baxter and Jack (2008) and Miles and Huberman (1994) provide the foundation for this current study's methodology. I outline details on the data collection, the coding, and the presentation of the findings.

In Chapter Five, 'Findings', each participant's practice context is presented and cross-case analysis reveals themes that were derived from the responses to the research instrument, in this study.

In Chapter Six, 'Summary Discussion, Limitations, Implications and Conclusion' are discussed according to the participants' responses to the research instrument.

In summary, this chapter has provided the background and the rationale for this current study. My experiences as a social worker and researcher, my feminist beliefs and my desire to learn more about disabled women's experiences are part of the path that I have followed for this research. This chapter has traced the steps of my journey that began with an interest to end male partner violence against women and grew into a passion to end male partner against disabled women. In the next chapter, social work history and the challenges related to the definitions of partner violence and disability are discussed.

Chapter Two - Literature Review

This chapter includes a brief review of social work's history in relation to disabled people and provides an examination of disabled women and MPV. The debate on how to define disability and violence against women continues because, there is no universal agreement (DeKeseredy, 2000; Thiara et al., 2012). Yet, how social workers define disability and male partner violence against women is important, because how disabled women are viewed and how certain violent behaviors are identified determines the solutions to end the violence (Thiara et al.).

Disability and 'Normality'

One concept that first distinguished and defined disabled people in contrast to non-disabled people was the notion of 'the norm' (Rothman, 2003). The norm as a concept was drawn from advances in the field of statistics, at a time when the French statistician Adolphe Querelet (1796-1847) developed a composite of the average man (Rothman). People endeavoured to become like 'the average man', because they believed that he embodied everything that was positive and worthwhile to achieve (Rothman). When statisticians did their calculations and made their bell curves, some individuals were left out of this norm (Rothman). As a result, negative connotations were attached to people who were identified as being outside of those parameters; they included poor people, disabled people, as well as criminals (Rothman, 2003). These deep seated perceptions continue to be part of mainstream society today (Prince, 2009).

In 2004, a Canadian representative sample of 1,843 individuals reported on their attitudes Association of Social Workers' towards disability (Prince, 2009). Even though the majority of Canadians wanted to think of themselves as being inclusive, when it came to disabled people,

many revealed their biases by specifying that they would be uncomfortable with some types of disability (Prince, 2009). For example, many respondents stated that they would be made uncomfortable by behaviour that was not considered 'normal' and one particular respondent said that he would only be at ease with a visible disability, as long as it was not 'unsightly' (Prince, 2009). We have to ask ourselves, if these biased attitudes are representative of all Canadians, how do they impact social workers' practices? In particular, are social workers' views and understanding of disability in line with those of mainstream society, are they different or do they follow the Social Workers' Code of Ethics? The Canadian Code of Ethics (2005) stated that "social workers [should] not discriminate against any person on the basis of age, abilities, ethnic background, gender, language, marital status, national ancestry, political affiliation, race, religion, sexual orientation, or economic status" (p.7). Although social workers' beliefs and attitudes should be in line with the Canadian Association of Social Workers' Code of Ethics, the language that they use in their practices may also prove to be revealing.

Defining Partner Violence

 Deconstructing the violence against women discourse is equally important because as Hugman (1991) remarked it is the language that is used that determines how it is perceived. For instance, gender neutral terms such as domestic violence or spousal violence ignore the gender power imbalance that disguises the fact that violence tends to be directed at women (Ontario Women's Justice Network, 2013). In fact, women and a greater number of disabled women are more likely to be abused by their male partners, than men abused by their female partners (Mays, 2006; Ontario Women's Justice Network, 2013).

The debate on how to define violence against women continues because, there is no universal agreement, when it comes to defining male partner violence against women

(DeKeseredy, 2000). Yet, the definition and construction of male partner violence against women is important, because how we understand a problem sets the context for recognizing certain behaviors as violent and for determining solutions to end the violence (Thiara et al., 2012). The use of severe violence and control, called 'intimate terrorism,' is mostly perpetrated by men, with more severe injuries inflicted on women, than vice versa; while low level violence between intimate partners is more likely to be bilateral (both partners inflict violence on each other) and is less likely to include forced sex and controlling behaviours (Kelly, 2011; Johnson, 1995). While, there is no single definition of male partner violence in relation to disabled women, violence is considered a crime and involves an imbalance of power and control between the individuals involved (Ontario Women's Justice Network, 2013; Nixon, 2009).

Even though there have always been laws against assault, it was not until the 1980's that the legal response towards violence against women changed (Ontario Women's Justice Network, 2013). In 1982, the New Democratic Party (NDP) Member of Parliament, Margaret Mitchell was laughed at in the House of Commons, when she brought up the issue of violence against women (Morris, 2013). The uproar from women gave national attention to the issue (Morris, 2013). Until then, men rarely faced consequences for beating their female partners (Morris). In 1983, federal rape laws were broadened to sexual assault laws and for the first time in Canada, it was a criminal offence for a man to rape his wife (Morris). By 1994, police in Ontario had been directed by the provincial Attorney General to lay charges in cases of violence against women (Ontario Women Justice Network, 2013). Mandatory charging was meant to send the message that violence against women would not be tolerated however, the response did not necessarily address the needs of all women (Ontario Women Justice Network). In fact, these new guidelines were largely dependent on police officers' discretion and were potentially open to abuse and

manipulation (Ontario Women Justice Network). These new mandates led to increases in dual arrests, placed women at a higher risk of retaliation from their abusers if charges were laid, it meant that single-income households could lose their sole means of support if their spouses were charged or incarcerated, and immigrant women feared deportation if they reported their partners for abuse (Ontario Women Justice Network).

It seems that distinct issues continued to plague disabled women who disclosed experiences of male partner violence (Nixon, 2009). Disabled women who were being abused by their male partners were often not believed by the police and/or their allegations of violence were frequently minimized or not taken seriously (Nixon). Professionals such as police or social workers may fail to understand or recognize instances when disabled women are abused by their male partners choosing instead, to shift the focus on the disability, thereby, overlooking the violence (Nixon). Yechezkel and Ayalon (2013) found that social workers typically dismissed abuse in older disabled women and that professional training needs to focus on the identification of abuse and social workers' subsequent interventions.

The Construction of Disability and Violence

Discourse that is used to define disability and violence constructs how these experiences are perceived and interpreted (Hugman, 1991). Hugman's foundational work suggested that discourse is about more than language.

Discourse is about the interplay between language and social relationships, in which

some groups are able to achieve dominance for their interests in the way in which the

world is defined and acted upon. Such groups include not only dominant economic

classes, but also men within patriarchy, and white people within the racism of colonial

and post-colonial societies, as well as professionals in relation to service users. Language

is a central aspect of discourse through which power is reproduced and communicated.

(Hugman, 1991, p.37)

In addition, Van Dijik (1989) a founder of critical discourse, stated that "lexical choice and the

use of identifying pronouns and demonstratives also suggest social distance: [for example],

'them', 'those people'…," (p. 35). Van Dijik suggested that prejudice had become more subtle

and that Western dominant groups tended to monitor their choices of discourse in order to hide

their biases.

Still, researchers have struggled to find operational definitions for 'disability' that are

complete, global, do not change over time, and take social locations into consideration (Gronvik,

2009). The issue with disability as a concept is that it is complex, can be defined in several ways,

may change over time and sometimes has contradictory meanings (Gronvik). Barnartt (2010, p.

3) defined disability as "…a relationship between impairment (physical state), functional

limitations, and disability is neither fixed nor permanent but fluid and not easily predicted".

In contrast, quantitative researchers have defined disability by categorizing disabled

individuals by functional limitations while, social policy makers are likely to define disability by

assigning people to groups that are either 'disabled enough' to receive benefits or not 'disabled

enough 'to receive benefits (Gronvik, 2009). Finally, some authors use a subjective definition of

disability and leave the conceptualization of disability in the hands of disabled people themselves

(Gronvik). The majority of disabled researchers prefer the term 'disabled individual' and reject the term 'persons with disabilities', in order to call attention to the fact that the disability is not 'with' the individual, but it is dominant society that 'dis-ables'; it is a way to reclaim power, by disabled people (Priestly, 1999). Other researchers and disability activists prefer the term *people with disabilities* because they believe that it puts 'people' first, before the disability (Healey, Humphreys, & Howe, 2013).

The World Health Organization (WHO, 2011) defined disability as:

An umbrella term for impairments, activity limitations, and participation restrictions. Disability refers to the negative aspects of the interaction between individuals with a health condition (such as cerebral palsy, Down syndrome, mental health issues [such as depression, anxiety, panic attacks]) and personal and environmental factors (such as negative attitudes, inaccessible transportation and public buildings, and limited social supports. (p.7)

While, The United Nations (2008) specified that disability "…is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others" (p.2).

Touchie, Thomas, Porter and Regan (2016) wondered if an invisible disability such as hearing loss or mental health issues can be considered an advantage or disadvantage. These same authors argued that there are both "advantages and disadvantages to not having an obvious disability. Ultimately, however, [they suggested that it is] society's reaction to the disability that renders the invisibility advantageous or not" (Touchie, Thomas, Porter and Regan, 2016, p. 14).

The question remains, what is 'normal'? Morris (1991) noted that mainstream society has been unsuccessful when it comes to accepting bodies that are normal but 'different'; it has been presumed that different bodies require 'fixing'. The World Health Organization's International Classification of Functioning, Disability, and Health (ICF) and the more recent WHODAS2 (World Health Organization, 2010; 2016) questionnaire was designed to capture the limitations and restrictions of activity experienced by individuals, regardless of their medical diagnosis, yet it did not take into consideration environmental factors (e.g., accessibility) that could be disabling (Oliver et al., 2012). This perspective has failed to capture negative attitudes and environmental barriers that could be disabling (Oliver et al.).

Ironically, the assessment included questions about the person's environment but the coding was on functioning and disability, not on barriers in the environment (Oliver et al., 2012). This omission suggests that the data collected to inform policies were not interpreted as they might have been. Perhaps the questions were formulated as they were to support existing mandates or policies, because if researchers had coded for the limiting effects of the environment, policy makers might have identified contexts that needed specific policies, to ensure accessibility for disabled people. Additional critiques are proposed by critical feminists, when it comes to disabled women and non-disabled Western society (Curry, Hassouneh-Phillips, & Johnston-Silverberg, 2001; Hiranandani, 2005; Mays, 2000).

How a Patriarchal Society Defines Disabled Women.

Critical feminist disability scholars have reported that in the context of a patriarchal, capitalist, and ableist (e.g., a society that discriminates against disabled people) society, disabled women are constructed as being valueless and are frequently subjected to ubiquitous stereotyping (Curry et al., 2001; Hiranandani, 2005; Mays, 2006; Nosek et al., 2006; Rowe, 2009; Thiara et

al., 2011). Disabled women are consistently and stereotypically presented as vulnerable, submissive, immobile, asexual, and as men's fetishes in social media (Elman, 1997). These gendered depictions of women's bodies reveal political aspects that reproduce the prevailing culture (Reed, 1997). What this means is that disabled women's bodies are considered deviant, when measured against the "…more or less taken-for-granted body talk, that makes the able-bodied, rational, male subject, the normative standard in society and shapes the sense of who we are and how we interact with others " (Ahlvik-Harju, 2015, p.10).

A premise of the critical and feminist disability perspectives stress that the structure of society is based on an individual's status within the socio-political system (Barile, 2002; Mays, 2006). This individual status is usually determined by those with more power within the social hierarchy; "…historically, this has been men and the non-disabled majority" (Barile, 2002, p.1). The more layers of distinction between an individual and those who hold the power (e.g., disabled women vs. able-bodied white men), the further away one is positioned from social acceptability and the greater the inequity that is experienced (Barile). This becomes evident when we understand that most of our knowledge about disability has been derived from non-disabled people's construction of disablement and as such is akin to accepting a male construction of women's lives (Barile; Barnes & Mercer, 2004). A man's perception is not necessarily created in a deliberate attempt to oppress women, but men have nonetheless benefited from their dominant position in relation to women (Barile); similarly, non-disabled individuals have equally benefited from their privilege, in comparison to disabled individuals.

Even though social workers and other professionals may be disabled themselves, it is useful, not only to challenge definitions of disability and what is considered 'normal', but to be critical and refrain whenever possible from imposing an assessment of needs, that reflects the

dominant perspective of disability, that it is an individual problem; instead, professionals including all social workers should strive to be open and to support disabled people's voices (Oliver et al., 2012).

In 2003, the Office for Disability Issues (ODI) of the Canadian Government produced a report that focused on defining disability. Their goal was to clarify the meaning of disability across social programs, in order to establish eligibility criteria for services (ODI, 2003). What they found was that one definition did not fit everyone and that disability is a complex phenomenon that cannot be easily defined to suit the needs of policy makers (ODI). Despite this, they agreed that for the most part, program eligibility would be based on the certification of the disability, by a physician (ODI). This meant the Government of Canada would continue to rely on medically classified terms, to define disability as an individual problem and would not be taking environmental barriers into consideration. A critique that may be levied against this definition is that it fails to support disabled people's perspectives, because it excludes the context, (e.g., environmental and social barriers) that have been shown to impact disabled people (Oliver et al., 2012).

Disabled Women and Male Partner Violence.

In the fall of 2012, Statistics Canada conducted a survey called 'Disability in Canada' and found that 14.9% of women aged 15 and over had reported a disability (had a limitation in daily activity) compared to 12.5% of men (Statistics Canada, 2013b). This same survey found that women reported more disabilities, in all age groups compared to men (Statistics Canada, 2013b).

In 2013a, Statistics Canada noted that 80% of police-reported partner violence cases were inflicted on women by men; however, they did not specify if any of these women were disabled.

There are almost two million disabled women in Canada (Rajan, 2011) and nearly one in two experience male partner violence (Thiara et al., 2012). In a recent German study, disabled women experienced male partner violence at a rate that was two to five times greater, than non-disabled women (Schrottle & Glammeier, 2013). Ballan et al.'s (2014) retrospective study of 886' disabled women who had experienced MPV found that almost half were married and two thirds had children. Disabled women who had children were more likely to seek protection orders in comparison to disabled women without children, perhaps in an attempt to protect their children (Ballan et al.). Disabled women are more likely to experience male partner violence if they have a male partner who is also a carer and abuses alcohol, if they are in a longer term intimate relationship, are older, are poor, or Aboriginal (Brownridge, 2006).

> Women with activity limitations…[such as] having difficulty in their daily life or a physical or mental or health problem that limited the quantity or type of activity they could engage in…had twice the odds of experiencing intimate partner violence than women without activity limitations. (Vecova Centre for Disability Services and Research 2011, pp. 5-6)

Although violence can occur in a range of relationships including those that are heterosexual, gay, lesbian, transgendered, including those in which women perpetrate partner violence, the vast majority of partner violence is experienced by women and is perpetrated by men (Coker, Smith, & Fadden, 2005).

Male partner violence against women may result in a disability due to injury (Radford, Harne, & Trotter, 2006). For example, some women have lost their sight, their hearing, have developed mental health issues, had their mobility impaired or experienced exacerbation of an existing disability (Radford et al., 2006). The B.C. Society of Transition Houses (2011) reported

that partner violence had a bearing on women's mental health. Dutton, Kaltman, Goodman, Weinfurt and Vankos (2005) found that the risk of developing depression, posttraumatic stress disorder, depression and suicidal behaviors was higher in women who had experienced partner violence compared to women who had not. Scherer, Snyder and Fisher (2013) specified that disabled women (physical or learning impairment or mental health conditions such as schizophrenia, bipolar or others) were more likely to experience MPV compared to non-disabled women but also argued that MPV could result in a disability.

Abusers could take advantage of their mental state by withholding their medications by threatening to have their children taking away or by having them institutionalized (Golding, 1999; Thiara, Hague, Bashall, Ellis, & Mullender, 2012). Despite these risks, Hassouneh-Phillips and McNeff (2005) conducted a qualitative study and found that women with physical disabilities who had negative self-perceptions about their bodies and a strong desire to be partnered tended to stay in abusive relationships longer because they did not want to be alone.

Even though all women who experience MPV face challenges such as financial hardship, the fear of losing children, stigma, or fear of not being believed by professionals when they try to end the relationship, disabled women contend with further barriers (Nixon, 2009). They may fear being institutionalized if they leave their male partners, experience increased dependence on their partners, and they may not have access to shelter information or resources (Nixon).

Even the most recognized theory of power and control, Walker's (1979) theory on the cycle of violence does not adequately depict disabled women's experiences of male partner violence (Dutton, 2002). The cycle of violence is described by a phase of escalating anger and tension building, followed by a violent phase that serves to release the tension and ends by a period of regret and promise of reform (Dutton). Copel's (2006) qualitative research work with

disabled women found that those who perpetrated male partner violence upon disabled women, did not express regret or remorse after the violence. In fact, the terms used to describe the perpetrator's demeanor after the violence were "…pompous, powerful, controlling, devious, and righteous rage", indicating a more complex experience for disabled women (Copel, 2006, p.123). In another study, one disabled woman described her experience by saying that:

> It was sex all the time, twice a day. He would hold me down with his hand over my mouth always, and I hated it, I hated it. He said because I was Deaf, I deserved it…he'd turn off the wheelchair and leave me there and walk away, or—this is a good one—move it to one side, just as I was shifting myself into it. (Hague et al., 2011b, p.124)

Unfortunately, there is a lack of specialized resources for disabled women who experience complex partner violence as described above; services such as accessible women's shelters and information (e.g., in large print or simple language) that can affect disabled women's access to life-saving information, their capacity for self-protection, and can produce a sense of vulnerability and isolation (Johnston-McCabe, Levi-Minzi, Van Hasselt, & Vanderbeek, 2011). Plummer and Findley (2012) found that male partner violence against disabled women could result in depression, anxiety, fear, physical injuries and the exacerbation of existing disabilities.

Reasons why disabled women remained in violent relationships longer than non-disabled women were the lack of accessible information, the fear of institutionalization and the disbelieving attitudes of professionals, that made it difficult for disabled women to convince them, that abuse had occurred (Copel, 2006; Plummer & Findley, 2012).

Research has only begun to consider the distinctive and complex factors that affect disabled women, who experience MPV (Barranti & Yuen, 2008; Gilson, Cramer, & DePoy,

2001). For instance, it is not uncommon for disabled women to have had multiple experiences of abuse throughout their lives in various contexts and relationships and they may have been abused by helpers, professionals, partners and other family members (Thiara et al., 2012). Male partner violence usually includes physical, psychological, emotional, financial, and/or sexual abuse but for disabled women, it may also include the manipulation of medication or mobility aids, neglect, destruction of mobility or communication devices, refusal to provide essential personal care, isolation, and threats of institutionalization (Powers et al., 2009). Many disabled women have in the past, and, in some instances today have been isolated and their sexuality has been infantilized, they tend to be ill prepared to address unwanted sexual attention, let alone power issues in intimate relationships, and lack confidence when it comes to leaving abusive partners (Thiara et al., 2012).

Disabled women tend to have lower incomes, lower rates of employment, and experience higher rates of violence (Brownridge, 2006; Neath, 1997). There is no question that disability is a gendered experience for women because disabled women typically have fewer choices in their lives in terms of education, individual income, relationships, and life circumstances compared to disabled men (Gold & Auslander, 1999; Hague et al., 2011a; 2011b; Thiara et al., 2012). Yet, according to Lloyd (1992), the women's movement has rarely taken disability issues on board; for this reason, disabled women have found the disability movement more approachable, than the women's movement.

Another important point is that disabled women's experiences of MPV are more complex than non-disabled women depending on their particular disability, race, color, social class, ethnicity, culture, history, geographic location and no single definition of disability or male partner violence applies (Mays, 2006). Some disabled women may be faced with compounded

oppression; a disabled woman who is black and older may also experience ableism, sexism, racism, and ageism (Thiara et al., 2011). Ableism was described by Bolt (2015, p. 3) as a term that "…renders people who are not disabled as supreme".

Cripps, Miller and Saxton-Barney (2010) reported that disabled Indigenous women who had experienced violence had difficulty accessing services, because professionals lacked the necessary knowledge to assist them. One disabled Indigenous woman who required an interpreter because she was deaf was denied the service and the reason given was that it was too expensive (Cripps et al.). Another Indigenous woman in this same study said that social workers did not see her disability needs, because they were focusing on the fact, that she was Indigenous (Cripps et al.).

Indeed, not everyone supports the notion of compound oppression; rather, some intersectionality advocates believe that race, age, disability, and gender intersect as a unique and simultaneous experience (Bograd, 2005; Crenshaw, 1991; Samuels & Ross-Sheriff, 2008; Wendell, 1996; 2006). This means that diverse or similar oppressions are experienced differently in a variety of contexts (Samuels & Ross-Sheriff, 2008).

Other researchers have been reluctant to embrace the intersectionality perspective because they are concerned that it will contribute to a dilution of a shared collective identity (Little, 2010; Swain & French, 2000). Collectives are safe spaces in which oppressed people can develop oppositional identities and counter-hegemonic perceptions of the world (Little). For example, in these safe contexts, disabled individuals can have physical and ideological distance from unsupportive environments, creating spaces where, alternate worldviews can develop (Little). Disabled women may find that collectives increase their self-esteem, by providing a

non-tragic perspective of disability and by showing that disabled women can lead fulfilling lives (Swain & French).

Social Workers and Disabled Women

Insight into social workers' early involvement with disabled people affords contextual evidence that demonstrates how today's relationships between disabled people and social workers evolved. Conversely, specific written history of disabled women is more recent and limited (Thiara et al., 2012). Ellerington and Stuart (1990) stated that "contrary to the long history of the mainstream women's movement, the movement of disabled women in Canada only began in 1985, when 25 women first met in Ottawa…" (p.19) to discuss issues that were of concern to disabled women. Driedger (1992) made a similar statement by saying that:

> While the history of all disabled persons has been largely buried and ignored, men still have more of a presence than women, as they were the disabled war vets who came back. There is little mention of the disabled women civilians from the war years though. (p. 91)

More recently, even though social workers have worked with disabled and abused women in various settings such as healthcare, child and family services, women's shelters, private practices and crisis shelters, disabled women's issues are not frequently discussed in social work research (Oliver, 2004; Oliver, 2009; Oliver et al., 2012; Shier, Sinclair, & Gault, 2011; Thiara et al., 2012) and according to my literature search, little is known about social workers' perspectives, their practice contexts and their work with disabled women who have experienced MPV.

This absence is a symptom of a much larger issue; in particular, that disabled women are often, invisible (Oliver et al., 2012). Hague et al., (2011a) remarked that disabled women are so devalued that they tend to be considered invisible and asexual by mainstream society.

Large scale studies have generally excluded disabled women as participants therefore, less is known about their experiences of MPV compared to non-disabled women (Hague et al., 2011a). In 2008, Dawn Canada conducted a survey to determine women's shelter accessibility and found that many shelters claimed to be accessible; however, 45% of shelters had turned away some disabled women (Smith, 2009). In many cases, the reasons for not being able to accommodate disabled women were related to inaccessible spaces such as entranceways, hallways, stairs, and bathrooms (Smith). Shelters also turned away disabled women with mental health issues more often, than any other group of women and the reasons they gave were the complexity of the women's needs, the difficulty that some women had living with others and the inability to accommodate unstable women, who were on medication and who were unwilling to enter treatment programs (Smith).

Even though disabled women have expressed their concerns about the lack of disability awareness in their experiences with professionals (e.g., social workers, healthcare workers and police), ironically, they added that when they did leave their abusive relationships, it was because a social worker or healthcare professional had shown them kindness, respect, and compassion (Rajan, 2011). However, history indicates that this may not have always been the case, when it concerns disabled people.

Social Work's Historical Context and Disabled People

The historical context is significant for understanding how relationships between social workers and disabled people have developed over time and why various perspectives are maintained today. In the early 1900s, the Canadian profession of social work emerged from Christian charity work and the settlement movement (Jennissen & Lundy, 2011). Charity workers were mostly focussed on the individual and poverty was viewed as a personal failing

(Jennissen & Lundy). No charity was dispensed unless it was apparent that circumstances beyond an individual's control (e.g., disability, old age) were responsible for his or her predicament; in other words, individuals were perceived as either deserving charity while, others were not (Jennissen & Lundy). The role of charity workers was the management of the deserving poor, or as often was the case, disabled people; while the settlement workers stressed the social and economic conditions that afflicted the underprivileged (Jennissen & Lundy; Stuhler, 2013). During this same era, poor and disabled individuals were often housed in workhouses or asylums (Dunn & Langdon, 2016). Some communities lacked resources to build workhouses and held annual auctions of poor and disabled people (Dunn & Langdon). As a result, disabled people were frequently neglected and died (Dunn & Langdon). By the mid-nineteenth century, most large centres in Canada had built institutions for disabled people who were considered 'insane' (Dunn & Langdon).

During this time, social work was mostly focused on casework that was influenced by psychiatric theory (Jennissen & Lundy, 2011; Mackelprang & Salsgiver, 1996; Stuhler, 2013). Casework was defined as helping individuals adjust to the social order, in other words, to the society of the time (Marshall & Jones, 1937).

> Some social workers, such as Bertha Reynolds, the associate director of the Smith College School for Social Work, had difficulty embracing the disease model of practice inherent in psychoanalytic techniques. Because of her humanitarian concerns and belief in the need for social reform, Reynolds's emphasis remained on the psychological adjustment, not the cure, of mental patients (Reisch, 1998, p. 172).

Classification.

Another perspective was offered by Parr (2008) who argued that specific events had directed the gradual progression of classifying and defining disabled people; in particular, the Elizabethan Poor Laws of 1601 (Bloy, 2002) and the British Vagrancy Act of 1714. Workers were making individual assessments to provide or withhold access to charity (Jennissen & Lundy, 2011). In that sense, workers engaged in the identification of individuals and classified them under categories, such as the worthy poor versus unworthy poor (Jennissen & Lundy; Malacrida 2015).

Later, during the development of the capitalist society, disabled people, the old, and the poor were defined as the 'other' because they were deemed unproductive (Parr, 2008). Hansen (2002) suggested that productivity and physicality was and remains an especially valued commodity in Western society and those who fail to meet these standards are singled out, as not fitting in. Indeed, defining individuals as disabled resulted in significant economic, psychological, and financial consequences in people's lives (Wendell, 1996, 2006). As such, it is reasonable to say that disabled individuals were obligated to apply for social services benefits.

The nature of social work and its place within the delivery of social welfare policy, meant that there were instances, when social workers would determine social services eligibility (Wendell, 1996, 2006). Wendell (1996) recounted how Jean Stewart had described a constellation of perceptions behind the questions of her social worker, when she asked for money to buy a wheelchair:

> The client-applicant is ineligible for services until proven eligible. The client-applicant's vocational goals are outlandish, greedy, arrogant, [and] must be trimmed down to appropriately humble scale. The client-applicant's motive in seeking services is, until

proven otherwise, to rip-off the system. The function of the Agency is to facilitate

adaptation of client to job. The client is a fraud. The client is helpless. (p. 42)

This passage depicts the absurd rules or assumptions that might have governed the assessment of

needs, by social workers (Wendell, 1996). Doyal and Gough (1991) proposed that the assessment

of needs was and remains a 'colonialist approach' as it concerns one group determining what is

best, for another less powerful group of individuals.

In contrast, we cannot overlook Ploesser and Mecheril's (2011) notion that social work is

conflicted with the concept of difference and 'otherness'. Ploesser and Mecheril argued that if

social work discounted differences, "…[it would be] criticized for concealing power relations

and for taking the dominant white male model as a neutral and universal indicator [of dominant

society]. Judged against the norms of the majority, the 'otherness' of the 'others', their strategies,

capabilities and social characteristics, [would become] a deficiency" (p. 797). These same

authors proposed that if social work acknowledged differences, they might be criticized because

as soon as individuals are recognized as different, they are perceived as 'the other' (Ploesser &

Mecheril). Ploesser and Mecheril found this was the case in their study of youth and differences.

When workers were asked to note down who came to a youth centre, the youth were identified

by their perceived physical traits such as male, female, non-disabled, disabled, or by ethnicity

(Ploesser & Mecheril). For these reasons, Ploesser and Mecheril emphasized the need for social

work to engage in critical deconstructive approaches of difference to argue for both sides of the

argument, by including and excluding difference and to shift the attention to "…partiality,

solidarity, and empowerment" (p.797).

In the case of disabled women, Thomas (2004) claimed that if we believe categories

divide able-bodied individuals from disabled individuals, then we view people's differences as

'real' and do not see that these differences are socially constructed. Social construction posits that truth is relative or subjective, because it relies on one's perspective; in particular, what we believe to be 'real' is actually, constructed (Baxter & Jack, 2008). Baxter and Jack (2008, p. 545) said "constructivists claim that truth is relative and that it is dependent on one's perspective".

Crabtree and Miller (1999, p. 10) suggested that this constructivist paradigm "…recognizes the importance of the subjective human creation of meaning, but doesn't reject outright some notion of objectivity". In research, participants are able to describe their perspectives, their understanding of reality and this enables the researcher to better comprehend the participants' actions (Lather, 1992; Robottom & Hart, 1993). For instance, Cockain (2014) explained that the definition of disability is constructed and reinforced in social relations. This is *not to deny that impairment exists* and may produce suffering, but it is to argue that disabled people are disabled by perceptions and inaccessible environments (Shakespeare & Watson, 2002). Oliver (1998) said:

> [That] impairment is the functional limitation within the individual caused by physical, 8mental or sensory impairment; disability is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others because of physical and social barriers. (p. 1447)

The notion of 'normality' does not really exist, because it is mainstream society that labels, excludes and oppresses disabled individuals, by constructing them, as the 'other' (Carniol, 2010; Thomas, 2004). Othering or the other refers to '…[marking] and [labelling] those thought to be different from oneself (Weis, 1995, p.17). Carniol (2000) suggested that the Social Work Code of Ethics is clear that social workers should work towards social justice and maintain what is best for service users.

Carniol (2000) said:

[In order to accomplish this, social workers]…need the knowledge necessary to address

the oppressive labels that have been psychologically internalized by social service clients.

As social service providers, we also need to know how these labels may have gained

acceptance not only within social service organizations but also inside ourselves as

individual practitioners. Working to promote social justice means working to change

harmful attitudes and practices. (p. 12)

Askew (2011) made an interesting analogy using libraries to demonstrate the

perpetuation of mainstream society's negative perceptions of disabled people. She said that

meanings are interpreted and reinterpreted at the crossing of ideology, practices, and the built

environment (Askew). For instance, libraries are supposed to be quiet environments and we

frown at people who refuse to be silent (Askew). Time and again, ideologies, practices, and built

environments construct and reconstruct libraries as quiet places (Askew). In the same manner,

we construct disabled bodies; they are created and recreated (Askew). "We construct bodies as

disabled when we patronize, infantilize, or sanctify people with particular bodies, perpetuating

and ultimately sedimenting their otherness to our sameness" (Askew, 2011, p. 2). This means

that we are creating who we are as mainstream society composed only of non-disabled bodies

and determining that disabled individuals are 'the other', who have different bodies (Askew).

Despite this reality, efforts that counter pre-conceptions of disabled people as being different, are

on-going (Brostrand, 2006). Due to new ideas being presented, Brostrand found that people who

had undergone disability sensitivity training, showed a significant shift in attitude; they were

more accepting and positive towards disabled people.

Continuing with a similar focus, Barnes and Mercer (2005) stated that the functional limitations perspective used by professionals to classify disabled individuals, according to their abilities, legitimized disabled people's exclusion from the labour market and placed them on the margins of society. This exclusion meant that disabled people were increasingly perceived and constructed as non-productive, in comparison to non-disabled people (Barnes & Mercer).

Not everyone agrees with this proposition, because Corker and Shakespeare (2002) criticized the notion of a constructed reality, as they proposed that it excluded the lived experiences of disabled people. According to Corker and Shakespeare, the overall experience of disability is too complex to be explained solely, by the notion that reality is constructed; they argued that people are disabled by their bodies, as well as structural and social barriers.

Despite these arguments, how disabled people are perceived by mainstream society affects how they are defined in comparison, to non-disabled people (Canales, 2000). Othering and labelling are processes that name, divide and stigmatize individuals (Canales). Once stigmatized, an individual's identity is damaged by the discrediting attribute and full social acceptance becomes challenging, because the person has been categorized as being different, from the rest of society (Canales); with this in mind, it is essential that the profession of social work be attuned to the effects that labelling may have on disabled people (Thomas, 2004) and that social work education include disability and partner violence in its curriculum (Black, Weisz & Bennett, 2010).

Social Work Education on Disability and Partner Violence.

In the United Kingdom and in Canada, there have been attempts to ameliorate shortcomings in social work education, as it relates to disability (Beresford & Boxall, 2012; Dunn et al., 2006). Beresford and Boxall noted that the United Kingdom's Department of Health

required institutions that offered social work degrees "…to involve service users and carers in the following areas: student selection, design of the degree, teaching provisions, preparation for practice learning, provision of placements, learning agreements, assessments of students and quality assurance" (p. 156). There was however, no specific plan developed to change the theories or models in the curricula of social work education or in social work practice methods with disabled people, in the United Kingdom (Beresford & Boxall).

In Canada, most schools of social work do include disability courses or disability content as part of their curriculum (Dunn et al., 2006). In the United States, Bean and Krcek (2012) found that there had been an increase in the overall inclusion of disability in social work education however, a closer look revealed that the number of social work courses that examined the topic of disability were lacking.

One area of social work education that could provide disability training for social work students is fieldwork (Ballan, 2008). Fieldwork that focuses on disability would provide social work students with enhanced skills and training to work with disabled people (Ballan).

In Canada Carter, Hanes and Macdonald (2012) reported:

[That]…most social work programs had several disability related field placements and a large portion of these placements included direct service provision to persons with disabilities. Given the strong probability that social workers will work with disabled persons, be it in areas of mental health, health care or working with elders, the connection to disability theory and practice often was not explicit, as the relationship of disability to field was not highlighted in most programs. (p. 120)

As mentioned, it is still the minority of social workers that are gaining insights from disability organizations and consumers of services for disabled people (Dunn et al., 2006;

Roulstone, 2012). These insights underline the importance of being reflexive in social work education and training in order to critically respond to practice challenges and attempt to shift power back to disabled people (Roulstone).

While, most MSW social work education programs do include some content on partner violence, Black et al., (2010) recommended that more needs to be done to inform students about partner violence. These same authors found that social work students were more likely to recommend counselling to women who had experienced MPV instead of some form of specific partner violence intervention indicating that their knowledge was limited. Black et al., (2010) reported that social work students had failed to discuss safety planning in their practices with women who had been abused, an indication that they lacked appropriate partner violence education and training. Students who had received more specialized training in partner violence were less likely to victim blame and experience burn out themselves (Black et al.). McMahon, Postmus, Warrener, Plummer and Schwartz (2011) found that specialized MSW courses on violence against women had an impact on social work students' negative attitudes towards women who had experienced MPV and improved their sense of professional efficacy.

The inclusion of disability and partner violence content is a relatively recent addition to social work education (Beresford & Boxall, 2012; McMahon et al., 2011) however, as evidenced in the next section, social work's involvement with disabled people is longstanding.

The Role of Social Workers after WWII and Disabled People

By the 1940s, WWII had drawn attention to many of the returning soldiers who had incurred injuries and amputations; these soldiers were viewed as disabled and required support to adjust to post-war civilian life (Beaulaurier & Taylor, 2001). Hence, during this time, the majority of social workers' practices were related to the medical rehabilitation of disabled

veterans; the role of the worker was to support the family and the veterans in adjusting to a life with disability (Beaulaurier & Taylor). In the United States, social workers feared that giving veterans benefits would create hostilities among social organizations; in the 1946 National Conference on Social Welfare Proceedings, social workers said:

> We see all service organizations greedy for members therefore, grievously fighting causes of individuals with grievances. We suspect them of bellowing first 'veterans first', so strongly that non-veterans are discriminated against in jobs, legislation, in benefits of all sorts. We suspect that unnecessary family, community and political frictions are created. (p.361)

Social work was mainly concerned with administering aid to veterans that was based on everyday needs (Oliver et al., 2012). For instance, workers were expected to assess veterans over a long period of time, raise their morale when required, help to determine the veterans' assets and limitations, get the veterans ready for jobs, make sure that jobs were available and obtain additional resources, such as occupational therapists (Neary & Granatstein, 1997, 2014). Social workers focused on the assessment of individuals' needs to determine, what was required to make them self-sufficient and employable; however, when it came to finding permanent work, disabled veterans were often discriminated against, because of their different bodies and were left on the economic margins of society (Oliver et al., 2012; Reaume, 2012).

Even though the Government of Canada had legislated priority hiring and seniority rights for veterans with the "Veterans Charter…a term used by the Government of Canada to characterize the compendium of legislation designed for the veterans of WWII" (Neary & Granastein, 2014, p. 86) to increase the likelihood that they would find employment, some employers were wary about hiring disabled people because they thought disabled people would

not be able to do the work, that was expected of them (Neary & Granatstein, 1997). Unions were not supportive of this legislation, because they feared that government intervention meant the end of their power and influence, over workers (Neary & Granatstein, 1997, 2014). Although many veterans did obtain part time or term positions, their attempts to gain permanent employment was blocked by regulations, that required a person to be considered physically fit (Neary & Granatstein,1997, 2014).

After WWII, a shift in social policy, meant the notion of charity for the 'worthy poor' was changed, to one of entitlement (Neary & Granatstein, 1997, 2014). This new way of thinking was the beginning of the welfare state; this welfare model was supposed to abolish judgement and benefit many poor individuals, including disabled people (Neary & Granatstein, 1997, 2014).

Even so, this welfare model was associated with a number of key failings and limitations, such as restrictions that were placed on service users (e.g., having to meet certain criteria to access social benefits), institutionalization of disabled people, a focus on social control, widespread abuse and neglect, shortcomings in the delivery of services, and the failure to ensure equal access and opportunity for disabled people (Beresford & Croft, 2001). With this in mind, Oliver et al., (2012) suggested that social work was preoccupied with the proficiency of this welfare system, instead of examining its role, in the delivery of social care.

Driedger (1992) remarked that

this [same] era also saw the rise of the rehabilitation profession; doctors, physiotherapists, nurses and social workers…became trained in how to deal with the 'problems' of disabled persons. This led to many more rehabilitated people, but it also medicalised all aspects of life for disabled persons. They were classified as sick and generally society excuses sick people from participating in everyday life. (p.82)

In Manitoba, an archived interview recording with H. Mann (1981) documented that after World War II, the government had signed a declaration of "freedoms from want". Mann noted that this declaration was a way to prevent people from suffering the way they had during The Great Depression. This social worker suggested that society had difficulty with this new way of thinking; she said that people had retained pre-war attitudes, that it was an individual's responsibility to work and take care of himself or herself and that it was not up to the government, to do so (Mann). The beliefs were such that "if I can make it, so can everyone else" and if you are "poor or disabled" then you just have to "learn to make the best of it" (Mann). Mann explained that in general, people were humane and did not want to see others suffer; however, most people congregated with others who were similar to themselves; therefore, they could not identify with people who were different.

After WWII, Mann (1981) argued that to a certain extent, social work was considered radical because it was going against mainstream attitudes; more specifically, she said that it was unconventional to support universal programs. In order to change societal attitudes or at least make government social programs more acceptable, certain populations, such as disabled people and the poor were portrayed as being entitled to social services, even though Mann said that "they felt humiliated because many did not work and had to accept social welfare", in order to survive (Mann). With this in mind, we can see how disabled people's identities may have been formed and how they persist today, mainly that "…the dominant social perception of disabled people is [that they are] dependent and not able to work because of their personal functional limitations…" (Oliver et al., 2012, p. 99).

More recently, Cunnah (2015) offered a somewhat different perspective by suggesting that "identity includes the way in which we see ourselves, how we see ourselves in relation to

others, how we imagine others view us" and that identity can also be transformed into a more positive self-perception, depending on the context (p. 214). For instance, disabled students had experienced positive identity transformations when taking university courses; an indication that the context was relevant when examining disabled people's identity formation (Cunnah). Despite these encouraging findings, Cunnah remarked that discrimination would not disappear overnight because it was not only rooted in assumptions and experiences but also in inaccessible environments. The following section includes social work's further involvement with disabled people, how disabled people were often excluded from participating in society and how this exclusion contributed to their identity in relation to mainstream society.

Disabled People's Societal Exclusion and Social Work.

More recent history has demonstrated how past events have come together to shape disabled people's experiences, how they are viewed and their location in society; "those who we can't, we won't, or don't imagine as potential participants are those who remain excludable…essentially, excludable is the dominant conception of disability that operates in everyday life" (Titchkosky, 2011, p. 41). Titchkosky appears to be suggesting that disabled people have been excluded from spaces that non-disabled people occupy, because mainstream society is unable to see them as being full participating citizens of society. "History shows that ignorance, neglect, superstition and fear are social factors that have exacerbated [the] isolation of persons with disabilities" (Wa Munyi, 2012, p. 4). Nevertheless, Titchkosky explained that disabled people are still excluded from some spaces because most accommodations and access procedures are granted on an individual case-by-case basis, depending on the environment. Non-disabled people especially employers, will often use the justification that we cannot accommodate everyone or we cannot afford to accommodate everyone (Titchkosky).

In particular, disabled people are stereotypically viewed as ineffective workers and unable to contribute to society in a meaningful way; therefore, only peripheral access (e.g., wheelchair accessible toilets and ramps) is provided thereby, satisfying the idea of universality without compromising everyday activities of non-disabled individuals (Hansen & Philo, 2007). This means that non-disabled people are likely, not inconvenienced when there is a change to the physical environment, to accommodate disabled people (Hansen & Philo). This view contributes to non-disabled people's perception that disability is an anomaly instead of evidence of human diversity (Hansen & Philo). Titchkosky (2011) clarified that physical spaces and structures are not without meaning and carry messages about who we are as a collective and about our social conceptions and classification of individuals. What is more, disabled people have been viewed as one group, with one history, even though disabled people have different disabilities, genders, and varied experiences (Mohamed & Shafer, 2015). Perhaps mainstream society's tendency to ignore differences between disabled people and especially, between disabled men and disabled women, could explain the relative absence of disabled women's histories (Thiara et al., 2012). Nonetheless, disability is a gendered experience, since disabled women are more likely to be perceived as dependent, face higher poverty rates, have less education and tend to be more isolated than disabled men (Mohamed & Shafer).

A contrasting view is that social workers have been able to identify disabled women's strengths and positive characteristics and it could explain why disabled women have not just reported negative experiences, but positive encounters with social workers (Kim & Canda, 2007). For instance, disabled people reported that social workers had been instrumental in obtaining transportation, in acquiring mobility aids, and in providing them with crucial emotional support (Kim & Canda). The reality is such that disabled people have conflicting reactions to

social workers; they have perceived them as allies or advocates, as paternalistic interventionists or as gatekeepers of imperfect systems (Stainton, Chenoweth, & Bigby, 2010).

Eugenics and Social Work

Disabled people's views of social workers were not just positive or negative but involved a whole range of perspectives (Stainton et al., 2010). For instance, these ambivalent responses to social workers may be understood by the fact that social workers were valued when they were ultimately part of the early system of support for people with intellectual disabilities yet, their efforts commenced under the eugenics inspired British Mental Deficiency Act (1913), that led to widespread confinement of people with intellectual disabilities (Bigby & Atkinson, 2010; Stainton et al., 2010).

In the United States, social work played an integral part in the eugenics' process, by assisting with identification and diagnosis of disabled people; this led to the sterilization or institutionalisation of many disabled people (Kennedy, 2008). Kennedy went on to explain:

> [That] while prominent social work leaders adopted eugenic language and supported eugenic interventions, many members of the social work profession's rank and file similarly embraced eugenics during this period. The National Conference on Charities and Correction (NCCC), inaugurated in 1879 and renamed the National Conference of Social Work (NCSW) in 1917, emphasized emergent practice methods in response to the pressing needs of the day, including the mentally deficient as an increasing menace to the well-being of society. (p.30)

In Canada, in an attempt to control disability in families, from 1928 up until 1973, the Government of Alberta passed a law that legitimized the medical community's forced sterilization of almost 3,000 disabled women (Quarmby, 2011). Similar sterilization laws were

passed in 32 US states, California being the worst offender having forced sterilization on over

20,000 individuals (Cohen & Bonifield, 2012). During the 1930's, California's forced

sterilization process was so successful, that members of the Nazi party asked Californian

eugenicists, for advice on how to run their sterilization program (Cohen & Bonifield).

These atrocities demonstrate that disabled people had rarely been accepted as individuals

with basic human rights and many were hidden away in asylums, institutions, special schools,

and basements (Rothman, 2003). According to Dunn and Langdon (2016) people with

developmental disabilities were housed in institutions that practiced the removal of teeth and

nails as way to control what they perceived as their violent behaviors. Disabled people were not

only perceived as abnormal and immured, but they became even more invisible, to mainstream

society (Rothman).

Disabled Women's Discourse in Social Work

While the discourses on disability and violence against women are increasing in social

work literature (McOrmond-Plummer, Easteal & Levy-Peck, 2014; Petersen & Lieberman;

2001) these topics are often discussed as separate issues (Hessle, 2014) and the result is a lack of

understanding, when it comes to partner violence complexities that disabled and abused women

face. In Oliver et al.'s (2012) text on disabled people and social work, disabled women are

mentioned in the parenting section however, these authors do not make a distinction, between

disabled men's and disabled women's experiences. A couple of exceptions are Lundy's (2004)

social work and social justice text and Wolfer, Franklin and Gray's (2013) decision cases for

advanced social work practice that do examine violence and disabled women's experiences.

On one hand, this lack of attention is surprising since the majority of disabled women

who have experienced MPV have probably interacted with a social worker at some point during

their lives, in child protection, welfare assistance programs, health, disability and insurance plans, shelters, legal settings, academia, disability organizations, or other community services (Slayter, 2009). On the other hand, it reflects the reality that disabled women who are abused by their male partners are often overlooked (Olsvik, 2006).

Whenever disabled women are hidden from view or constrained from participating fully in society, their risk of abuse increases (Nixon, 2009). Common perceptions of disabled women also play a role in how the dynamics of the violence are viewed (Nixon). Their perceived passivity, asexuality, and invisibility can make it more difficult, for disabled women to leave abusive relationships (Nixon). Professionals' denial or minimization of disabled women's male partner abuse may prevent them from living a life that is free from violence (Nixon); therefore, it is up to social workers and other professionals to shift perceptions, in order to increase the visibility of disabled women and to acknowledge their experiences of violence. Robbins, Banks, McLaughlin, Bellamy, and Thackray's (2016) study found that social workers were conflicted about intervening when women who were competent were being abused by their male partners. These same authors found that social workers in their study were more apt to intervene in partner abuse situations only, when the women had intellectual impairments, otherwise they believed that the law did not obligate them to get involved (Robbins et al.).

Although social work research on violence against women has increased in the last decade (Slayter, 2009); there has been less social work research in the areas of disability and domestic violence that has focused on disabled women who have been abused by their male partners (Thiara et al., 2012).

A few Canadian studies have examined male partner violence and disabled women; however, these studies were limited as they did not include more complex types of abuses such

as the withholding of medications, medical appliances or personal care (Cohen, Forte, Du Mont, Hyman, & Romans, 2006; Cohen, Forte, Du Mont, Hyman, & Romans, 2005; Du Mont & Forte, 2014). Interestingly, Cohen et al.'s retrospective study (2006) found that disabled immigrant women who had an activity limitation were associated with a greater risk for MPV. A different Canadian study by Yoshida, Du Mont, Odette and Lysy (2011) reported that disabled women who self-identified as having a non-Canadian cultural identity were more likely to have been abused when compared to Canadian disabled women.

Even though social workers have worked with disabled women who have been abused by their male partners, disabled women's issues are less likely to be discussed in research publications (Oliver, 2004; Oliver et al., 2012; Thiara et al, 2012). This paucity of research should be concerning to social workers who are expected to rely on the best evidence for their practices. Thiara et al., (2012) explain that there is

> A lack of research evidence in the UK and internationally…[For instance,] looking at the studies that have been carried out, it quickly becomes clear that there has been very little research in the UK itself on domestic abuse and disabled women in either the domestic violence or disability arenas. (p. 25)

This absence is a symptom of a much larger issue; in particular, that disabled women's issues remain hidden and their needs for social services, often go unmet (Oliver et al., 2012). In contrast, Thiara et al., (2012) suggested that when it comes to services and policies there are signs of improvements; governments and organizations are working together to develop strategic frameworks that will address the needs of disabled women who have experienced MPV however, there are still barriers such as a lack of funding and accessibility that need to be addressed.

Physical, Cultural, Political, and Ethical Contexts

Physical, political, cultural and ethical contexts influence how social workers deliver social services (Chisala, 2006). For instance, social workers who work in child and family social services agencies, in hospitals or in private practices will likely have different experiences because of the different laws, policies, and mandates, across these settings (Chisala, 2006).

Social welfare policies shape the social welfare system of the U.S. [and Canada]. The term social welfare refers to a nation's system of programs, benefits and services that help people meet the social, economic, educational and health needs that are fundamental to the maintenance of society. Social policies make it possible for clients to receive benefits and services they might desperately need. (Chapin, 2014, p. 3)

Moreover, specific federal or provincial legislation and policies are likely more apparent, for social workers who work with children and families and in hospitals rather, than in private practice settings. It may be difficult for social workers in a hospital setting to avoid using medical diagnoses and classify individuals (Chapin, 2014). Organizations have guidelines or rules, policies and priorities to which social workers are expected to conform to (Chisala, 2006). For example, social workers often have to rely on criteria (Chapin, 2014) set by The Canadian Disability Pension Plan, the Provincial Vulnerable Person's Act and the Provincial Income Support Act or Program, as well as healthcare professionals (Canada Benefits, 2016) to determine who is eligible for disability benefits or services (Stapleton, Tweedle & Gibson, 2013). To apply for disability support, The Provincial Income Support Act or Program includes criteria such as a physician's diagnosis, a financial report outlining the disabled person's income, being over 18 and not already collecting disability income from the Canadian Pension Plan (Stapleton et al.).

Social workers may have a good understanding of the significance of the physical environment on disabled people depending on their social work education or experience, but they may not always be able to advocate for disabled service users, such as gaining access to certain services, because of their accountability to their employers and legislative frameworks that authorize their interventions (Chisala, 2006). In many respects, agency efficiency or profit maximization, might be in conflict with social workers' desire to help services users (Chisala).

Furthermore, social workers may be expected to focus on delivering government services that reflect a particular political message or that follow certain regulations (Chisala, 2006); for example, certain organizations or governments may use the term domestic violence instead, of male partner violence against women (Canadian Department of Justice, 2015). It is possible that governments use the term domestic violence because it may be considered a more politically accepted, all-encompassing term, as it does not identify a specific group, as being responsible for violence that occurs in the family.

The ethical context becomes evident when social workers' professional Code of Ethics conflicts with a particular workplace setting (Chisala, 2006). The social workers' Code of Ethics (Canadian Association of Social Workers, 2005) may require that workers practice anti-oppressively however, this may be more challenging in a setting where a medical or individual deficit model is prominent, because the focus may be less on working with the whole person and more on 'fixing' the individual's body (Chisala). A real issue is that social workers frequently practice in settings, where some practices and procedures may go against their professional or personal values and principles, this may result in tension between social workers' desire to meet the needs of service users and fulfilling their employers' expectations (Chisala; Craig & Muskat, 2013).

While hospital culture may require social workers to work within a medical paradigm, Craig and Muskat (2013) contended that social workers are trained to look at larger social systems and not just focus on the service user's illness or disability. Social workers are unique in what they offer medical interdisciplinary teams because they provide access to community resources that are not offered by other professionals (Craig & Muskat).

When all these contexts come together, social workers may be "pulled between the individual and society, the powerful and the excluded, negotiating, and at times in conflict with both" (Chisala, 2006, p. 2) making advocacy for disabled women who have experienced MPV more difficult. Moreover, it is a well-known fact, that federal or provincial social policies and legislations are frequently part of the various work contexts that social workers find themselves in.

An Overview of Policies, Programs and Legislation Related to Disabled People

Disabled women who have experienced MPV are impacted by policies, programs and legislation that determine their eligibility for certain benefits and social services as well as their basic human rights (Murphy, 2016; Thiara et al., 2012). Perhaps Prince's (2016) description comes closest to describing the state of disability policies in Canada when he said that:

In using terms such as bundle, web, patchwork and net to indicate the nature of disability policy, the lesson to draw is that disability policy, in a collective overall sense, is not so much a closely tied-together pattern or coordinated network as it is a jumble of activities and inactions. (p. 102)

Previous and more recent Canadian Federal Government policies and legislation show entrenched discrimination and the battle that was required to win basic rights for disabled people that most non-disabled people typically take for granted (Peters, 2004). For example, in the

1980's, politicians first refused to include people with disabilities in the Canadian Charter of

Rights and Freedoms (Peters). The reason given was that discrimination was reserved for those

few who were recognized as visible minorities and who did not require such complex and

specific descriptions, such as disabled people (Peters). Hence, the Federal Government refused to

acknowledge that people with disabilities required protection under the Canadian Charter of

Rights and Freedoms, because they considered the disability discourse, to be too diverse and

complex (Peters). Intense lobbying by the Council of Canadians with Disabilities (1994, 2004)

formerly known as the Coalition of Provincial Organizations of the Handicapped (COPOH;

1976) and its allies outlined the fact that the exclusion of people with disabilities from the

Charter would create a first and a second class of human rights, the first class being all people

except disabled people and the second class being disabled people (Peters). Eventually, the

Canadian Government relented and people with disabilities were included in the Charter (Collin,

2012; Peters).

> The Canadian Charter of Rights and Freedoms (1982; part of the Constitution Act of
>
> Canada) protects equality, mobility, legal, democratic and linguistic rights of Canadians.
>
> In particular, Section 15 (which came into effect in 1985) ensures equal treatment before
>
> and under the law for five designated groups: people with disabilities, women, ethnic
>
> minorities, Aboriginal people, sexual and transgendered minorities. (McColl, Bond,
>
> Shannon & Short, 2016, p. 183)

Despite disabled people being included in the Charter, what remained challenging and

demeaning was the process that disabled people had to undergo to obtain federal or provincial

government services; disabled people had to provide evidence of eligibility showing that their

needs corresponded to certain benefits or services that were offered to disabled people (Peters,

2004). The problem with this determination was that it was and continues to be subjective, because it relies on professionals, such as social workers or healthcare professionals' assessment of disability, instead, of addressing societal and environmental barriers faced by disabled people (Peters). The implications of this professional assessment of disabled women who have experienced MPV is that it could mean that disabled women are refused social welfare benefits, if they do not meet the criteria.

Housing.

Federal legislation that has addressed the rights of disabled people include areas such as housing, employment, transportation, accessibility and discrimination (McColl & Stephenson, 2008). In 1979 and 1980 housing programs, such as the "residential rehabilitation assistance for persons with disabilities" (Bond & McColl, 2013, p. 23) that was developed by the Canada Mortgage and Housing Corporation provided some funding to homeowners and landlords to make dwellings accessible (Jongbloed, 2003). Vecova Centre for Disability Services and Research (2011) added that the Canadian Mortgage and Housing Corporation also provides financial assistance to repair or improve existing women's shelters or build new women's shelters or second stage housing (e.g., housing for abused women who have left their partners).

Employment.

In 1986 and later in 1995, the Canadian Employment Equity Act promoted the implementation of programs that would assist women, Indigenous peoples, visible minorities, and disabled people to join the workforce (Jongbloed, 2003). This meant that disabled women were supposed to be given employment priority by employers; however, in practice, few disabled women benefited from the priority hiring, because the Federal Government did not establish any enforcement procedures to support its own initiatives (Jongbloed).

Transportation.

In 1998 and later in 2011, the Federal Intercity Bus Code Policy stated that buses and bus terminals had to accommodate disabled individuals; while the Canadian Standards Association developed accessibility standards for disabled people and the Building Accessibility Act ensured accessibility (McColl & Stephenson, 2008; Public Works and Government Services Canada, 2011). The Federal Intercity Bus Code Policy included a commitment by bus operators to ensure accessibility for disabled individuals who were travelling without an attendant (Public Works and Government Services Canada, 2011). Bus operators were to provide assistance to disabled individuals; this consisted of helping disabled individuals to board and disembark the bus, fold mobility aids, obtain bus tickets from disabled people, and assist them in transferring to another bus when required (Public Works and Government Services Canada, 2011). These examples are indications that the Federal Government, in co-operation with the Provincial and Municipal Governments continues to be committed to a fully accessible national transportation system (Jongbloed, 2003).

Accessible Women's Shelters.

Vecova (2011, p. 9) reported that "569 shelters provided residential services to women and children across Canada" and the majority of these shelters had an entrance that could accommodate wheelchairs and had accessible washrooms. The rate of admission tended to be higher in Western provinces compared to the Eastern provinces (Burczycka & Cotter, 2011). Women who had been abused and who were living in rural had access to less resources compared to women in urban centres (Taylor-Butts, 2007). Vecova stated that 10% of the women who had been abused and who used shelters in Canada, self-identified as having a disability defined as having activity limitations. While most shelter workers were assigned

positive qualities such as empathy and helpfulness by women who have experienced MPV, one

barrier identified in several studies (Tutty, 1998; Tutty & Goard, 2002; Vecova) was that shelter

workers lacked specialized training to work with women who had been abused and had mental

health issues. Tutty & Goard stated that some women's shelter experiences were positive and

had saved their lives while, a few women reported negative experiences saying that shelters

workers had been judgemental towards them or did not have the time to counsel them. Tutty's

(2015) study found that women still experienced trauma symptoms upon leaving shelters

indicating that more supports need to be put in place for women who leave the shelters.

     Accessibility and Discrimination.

     Provincial Acts and programs that were implemented included Family Support Program

that was set up for families, to provide basic needs, including the provision of respite assistance,

the Human Rights Act that protects disabled people from discrimination because of their

disability, the Accessibility Building Act that requires public buildings to be accessible, the

Income and Employment Act that assists disabled people to remain in the workforce by

providing skills training and workplace accommodation, to name a few (McColl & Stephenson,

2008).

     When it comes to legislation and protection of vulnerable disabled adults, including

disabled women with intellectual disabilities, Vecova Centre for Disability Services and

Research (2011) reported that "Canadian legislation on adult abuse, neglect and guardianship is

addressed at the provincial/territorial level with each province creating their own response

framework" (p. 10). Jongbloed (2003) noted that in general, disability policies are splintered and

complex because they were incrementally developed. In some cases, these policies were part of

the welfare state policies, that were also fragmented and they did not address the complexity of

disabilities (Jongbloed). For this reason, the definition of disability was never properly addressed and programs were developed separately, to deal with the different needs of disabled persons (Jongbloed). The problem with these federal and provincial policies was and remains one that is related to economics; in particular, everyone agrees that disability benefits should be provided however, there is no consensus, on what the costs should be (Jongbloed).

Prince (2009) wrote extensively about the 'absent citizens' (i.e., disabled people who were not participating fully in society because of barriers) and disability policies in Canada; however, he did not include content that specifically related to disabled women. Whenever he mentioned disabled women, it was a brief comment, along with other intersections such as race or age. Yet, as mentioned earlier and as Schur (2004) found, disability is indeed a gendered experience because disabled women are more likely to experience social and economic disadvantages in comparison to disabled men.

Disabled women have been sought out for their views and ideas by researchers and policy makers however, Rajan (2011) and Vecova Centre for Disability Services and Research (2011) found that disabled women did not want to be consulted any longer, because they wanted to see concrete changes that included the setting up of support groups, the establishment and planning of strategies against abuse, an increase in disability sensitive resources, shelters and helping professionals, an increase in financial support, the development of safety protocols and protection services and increased awareness and education.

The Federal Government document, The Gap in the Gender Gap (2013) reported that over a million Canadian women had experienced MPV in the last five years and that the associated costs were close to 9 billion dollars (McInturff, 2013). Despite this fact, when the research was conducted, the Federal Government did not have a stand-alone policy or a plan of

action for ending male partner violence against women (McInturff). In the 2010 federal budget, the Government of Canada committed 10 million dollars, over two years to address the disproportionately high levels of violence experienced by Aboriginal women and girls (McInturff). It is important to note that there was no mention by the Federal Government, of funds to specifically address the more complex needs of disabled women who experience higher rates of MPV compared to non-disabled women (Brownridge, 2006; Neath, 1997).

On a more positive note, DAWN-RAFH Canada (2015) has launched a multi-year initiative that focuses on issues that pertain to violence against women with disabilities and Deaf women. This initiative will examine policy, legislation, and service gaps related to violence against women with disabilities and Deaf women (DAWN-RAFH, 2015).

Provincial Services Related To This Study

Most provinces and territories have specific policies and/or action plans to address male partner violence against women (McInturff, 2013) however, these policies could be more comprehensive by better addressing the complex needs of disabled women who experience MPV. It is difficult to derive reliable information about the impact of these provincial strategies, for any, but the most densely inhabited provinces, because small sample sizes do not make it possible to survey the affected populations in the smaller provinces and territories (McInturff). Provincial services (see Appendix A) that are discussed in this current research serve to establish part of the context, for the interviews that were conducted.

To summarize, the profession of social work began with charity and settlement workers. In the beginning, social work was influenced by various theories including psychiatric or diagnostic theories that focused on issues, within the individual as opposed to barriers, in the environment and social workers' practices, mostly involved case work. After WWII, social

workers worked with veterans and were expected to deliver the bare minimum, to those in need. A shift in social policy, meant the notion of charity for the 'worthy poor' was changed, to one of entitlement. This new way of thinking was the beginning of the welfare state; this welfare model was supposed to abolish judgement and benefit many poor individuals, including disabled people. Even so, this welfare model placed restrictions on service users and failed to ensure equal access and opportunity, for disabled people. Although social workers' knowledge about women's male partner violence has increased, disabled women's experiences of MPV are more complex than non-disabled women and they do not always have access to appropriate services. Although the Federal and Provincial Governments have implemented many policies and put forth legislation to improve disabled women's lives, more needs to be done by policy makers and social workers.

In the following chapter, theories, models and approaches that may have influenced social workers' work experiences with disabled women who had experienced MPV are examined.

Chapter Three - Theories, Models and Approaches

Social workers may be influenced by certain theories or models in their practice settings and in research with disabled women (Chisala, 2006; Payne, 1997).

Two differing streams of practice [that have been typically embraced in social work].
One has emphasized a paternalistic approach akin to the medical model, [where] a client's right to self-determination may be superseded by what the social worker determines is in the client's best interest [and more recently a] …model [that] has originated from the 'empowerment' approach. In this model, social workers view clients as possessing inherent strengths, resources, and knowledge. (Bransford, 2011, p. 33)

The Medical Model, the Social Model and Social Work

When social workers practice or conduct research that supports the medical (or individual) model of disability, their findings are likely to represent disability, as an individual deficit (Hanes, 2016; Oliver et al., 2012). Social workers who focus on the medicalized view of disability are likely to see disabled people as being ill, emphasize services users' limitations and their lack of compliance with medical directives (Dunn & Langdon, 2016).

In 1966, when Michael Oliver drew attention to the model by specifying that "…there [was] no such thing as the medical model of disability, there [was] instead, an individual model of disability…" (as cited in Shakespeare, 2006, p. 22). Shakespeare (2006) described the individual model of disability as the "…dominance of medical approaches and medical experts" (p. 23). Oliver (1990) said that it was the personal tragedy theory of disability that inspired the individual model. This same author explained that the personal tragedy theory views disabled people's issues as emanating from impairments that must be fixed by medical professionals instead of situating the problems in the environment (Oliver, 1990).

Kaplan (2000) suggested that the rehabilitation model is similar to the individual model as it considers disability to be a deficiency that needs to be fixed by rehabilitation professionals. The individual model was perpetuated through official statistics, because there was an assumption that statistics were objective and therefore, gave an accurate representation of the number of disabled people (Oliver et al., 2012). An important factor that was left out of the representation of disability was the context; there was a particular omission in the individual model to take into account, environmental barriers (Oliver et al.). Keeping this in mind, social workers need to take a fresh look at the theories and models that guide their practices with disabled women who have experienced MPV, to ensure the use of the most applicable theory or model possible (Oliver et al.).

Authors who write about disability have remarked that the individual model is related to practices and research that were developed by non-disabled people, with very few contributions from disabled people; yet, in some instances, the medical model still influences social workers' practices in settings, such as hospitals (Shakespeare, 2006; Shakespeare, & Watson, 2002).

Traditional medical theories or the individual model define disability in terms of individual deficiencies and biology that require fixing, medicalizing or minimizing while the social model implies that discrimination against disabled people, is rooted in dominant cultural perceptions, social oppression and the environment (Oliver, 2004; Oliver et al., 2012; Mackelprang & Salsgiver, 1996; Shakespeare, & Watson, 2002). Disability scholars have argued that in some instances, social work theories or policies continue to reflect perspectives that favor the individual or medical model (Oliver et al., 2012). When social workers apply solutions that are based on this type of framework, they may be focusing on the individual's disability (Oliver

et al.), as opposed to addressing her specific needs (e.g., such as assisting a disabled woman find work to ensure that she can be more autonomous and leave an abusive relationship).

Oliver conceived the term 'social model' or 'social model of oppression' in 1983 and it was the first perspective to set aside the individual focus of disability and to locate it in a social context (Shakespeare, 2006). This social model recognizes that disabled people are limited by dominant perspectives (e.g., disabled people are not productive therefore, why should employers make a workplace accessible?), biases (e.g., disabled people are asexual), environmental barriers, and non-accessible environments that are disabling (Quarmby, 2011; Thomas, 2004). Shakespeare and Watson (2002) claimed that the social model's main premise was that issues arose from social oppression (e.g., prejudicial attitudes against disabled people) and inaccessible environments and did not stem from individual deficits. For this reason, disabled people understood that they were not to blame, because society was the source of their problems (Shakespeare & Watson, 2002). Put another way, it was the lack of accommodation, accessibility (e.g., in transportation, buildings, employment etc.), the isolation and dominant society's prejudicial beliefs that prevented disabled people from participating fully in society, and not how disabled people performed in society (Quarmby, 2011; Shakespeare & Watson, 2002).

Beresford and Boxall (2012) along with Oliver (2009) argued that the social model has had an effect on disability policy but had not necessarily changed social work practice. For example, Oliver and Barnes (2010) specified that a United Kingdom federal report …"endorsed the importance of the development of policies [that would] enable disabled people …to achieve independent living…and that by 2025 disabled people [would have] full opportunities and choices to improve their quality of life…" (p.552).

Shakespeare (as cited in Quarmby, 2011) noted that the social model has both strong and weak points. On one hand, it improved disabled people's confidence, but on the other it was centered on white heterosexual disabled males, overlooked disabled women's issues, and denied the fact that impairment could cause suffering (Quarmby). Other issues have included the fact that the social model has not accounted for the intersections of gender, race, and disability, and that it has erroneously assumed, that everyone's disability is front and centre, when it comes to their identities (Quarmby).

Reeve (2012) remarked that the social model was typically used to identify and eliminate structural or material barriers (e.g., lack of accessibility) as opposed to barriers that operated at the psycho-emotional level (e.g., being stared at or subjected to oppressive attitudes). Psycho-emotional disablism in social work practice may happen when service users step outside of roles in which they were stereotyped (e.g., disabled woman gets pregnant), and the social worker reacts negatively (Reeve). Social workers need to understand the damaging effects that can occur in the self-confidence of a disabled person when negative or inappropriate judgements are expressed (Reeve). Reeve suggested that social workers may not always have control over inaccessible buildings, but they may exert influence over their own attitudes, to change situations and stereotypical assumptions (psycho-emotional level) and this in turn, could affect the service that they provide.

Social Work Approaches, Other Theories and Disability

Social work approaches may share some similarities with the social model such as the person-in-the-environment approach (Green, & McDermott, 2010; Rogge & Cox, 2001) however, disability advocates have critiqued those who have claimed a similarity to the social model, as not really addressing the needs of disabled people (Bailey, 2004; De Hoyos, 1989;

Mackelprang & Salsgiver, 1996). This is because the person-in-the-environment approach is primarily about intrapersonal and societal interactions while, inadequate attention has been given to the physical environment (Rogge & Cox, 2001). In theory, the person-in-the-environment perspective might seem applicable to the situation of disabled women who have been abused by their male partners; however, in practice, it is lacking a focus on physical environments that contribute to women's disability experiences (e.g., lack of accessibility), (Rogge & Cox).

Although social work has moved towards an ecological framework that, combined with the strengths-based approach, employs some aspects of empowerment, it has been variable in its practices with disabled people (Mackelprang & Salsgiver, 1996). Early ecological models were based on systems theories and were typically used by social workers to explain relationship processes, between family members (Ungar, 2002). These models were likely to ignore the position of the social worker in relation to the service user and the relative power, of each part of the helping system (Ungar).

In addition, the idea that a strengths-based approach is evidence-based remains controversial; on one hand, there is an argument for "…the strengths perspective showing that it is accountable, effective, and efficient in working with a specific group of clients…[but on the other, the strengths perspective] is reduced to fragmented and unconnected items of behavioral skills", such as a client's strengths (Yip, 2008, p.13). This statement implies that the strengths approach is too focused on one aspect and does not consider the environment or disabled persons' impairments.

A different focus such as empowerment has been a guiding tenet in both social work and the movement for independent living; however, social work depicts empowerment as a process in which professionals include clients in the decisions about their own care, such as anti-

oppressive approaches (Danso, 2009), while independent living views social workers as consultants and at the service of disabled people (Mackelprang & Salsgiver, 1996). It was Dejong (1979) that described the independent living model as identifying issues that arose from the societal oppression of disabled people, disabled people's history of exclusion and social and economic barriers encountered by disabled people. The independent living model has been described as having an "…emphasis [on] personal independence, consumer sovereignty, and consumer choice" (White, Simpson, Gonda, Ravesloot & Coble, 2010, p.235). This example underlines the importance of analyzing discourse and defining social workers' roles in conjunction with disabled people's objectives of autonomy, because as long as the power remains with professionals including social workers, power imbalances will persist and likely result in oppression.

Social work practice with disabled people has at times incorporated a capabilities approach, in combination with the International Classification of Functioning, Disability, and Health (Saleeby, 2006, 2011). There are two main features to this framework; the first is the capabilities component that considers individuals' potential and the second component is functioning, that assesses what individuals can do, according to their impairment and within their particular environment (Saleeby, 2006; 2011). There is support for this combined approach, in particular, that individuals' capabilities and environments interact to determine the resources that disabled people might have or require; however, this viewpoint fails to highlight the more profound environmental issues and biases, that add to disabled peoples' constraints (Saleeby, 2006; 2011). For example, this approach does not consider the dominant views, discourses, relationships, and societal barriers that, as discussed in chapter three, contribute to disabled

people's oppression, nor does it assess particular power relations (e.g., non-disabled vs disabled groups) (Saleeby, 2006; 2011).

Depoy and Gilson (2008) presented an alternative framework that attends to the aspect of disability differently, in theory and in the practice of social work. Explanatory legitimacy theory is a framework that positions disability in the context of human diversity while stressing social justice for all (Depoy & Gilson, 2008). Depoy and Gilson (2011) said that "…[the] legitimacy theory…dates back to 423 BCE…[and] seeks to analyze, detangle and clarify categorization and response by focusing on the source of authentication and valuation of explanations for category membership" (pp. 3-4). This approach interrogates the power behind the notion of 'justifiable' categories of disability and queries the need to label and categorize (Depoy & Gilson, 2008). Whenever practice approaches are used by social workers to classify bodies and minds' of disabled people as being different from 'normal bodies and minds', deficit is selected as the factor of membership, constructing disabled people's identities, as people who 'need help' (Depoy & Gilson, 2008). The explanatory legitimacy theory challenges the intention of classifying the body and the mind according to deficiencies, by shifting the focus to diversity and social justice (Depoy & Gilson, 2008). Depoy & Gilson (2014, p. 268) also suggest that disability be "rebranded…and that the scope of human appearance, activity and experience [be expanded] as typical and thus normal"; in other words, disabled people should not be excluded or discriminated against.

For example, a recent case involved a 5-month-old baby who was denied a heart transplant because the doctors suggested that he would develop infections and tumours due to his pre-existing medical condition (Cohen, 2013). When his parents did their own research and found out that their disabled son's condition did not put him at risk for infections, any more than

a non-disabled baby, they concluded that the real reason doctors did not consider their baby to be

a good candidate for a heart transplant, was because his existing condition was such, that he

would develop cognitive impairments when he grew up (Cohen, 2013). In other words, doctors

were discriminating by considering him to be less worthy of a heart transplant because he would

not grow up to be what mainstream society determines to be 'normal' (Cohen, 2013). Similarly,

Hanes (2009) remarked that disabled immigrants continue to experience discrimination. This

author suggested that disabled people were frequently classified as unproductive and were denied

the option to immigrate (Hanes, 2009).

In 2002, Oliver and Bailey examined various approaches that were used by social

workers to deliver services to disabled people. Oliver and Bailey (2002) intimated that social

work approaches consisted of three areas: humanitarian (based on a charitable framework and a

desire to help others where authorities are in charge of the services and users are expected to be

grateful); compliance (based on legislation and policy in which authorities do the bare minimum

to comply with the law when it comes to the delivery of services); and finally, the citizen

approach (focused on disabled people, as full citizens with all the rights and responsibilities

implied), (as cited in Oliver et al., 2012).

An alternative framework, the human rights-based approach is described as a

standardized strategy that is based on international laws (Katsui, 2008). This framework includes

the principles of empowerment, participation, non-discrimination and accountability (Katsui).

With the priority on vulnerable people, Katsui acknowledged this theory's valuable tenets of

non-discrimination, participation, empowerment and centered on vulnerable people,

accountability, but also put forth a critical perspective, by suggesting that the origin of the human

rights-based approach stems from Western beliefs, that may not be shared by other countries

(non-discrimination), that human rights are not well-defined and that narrow definitions of human rights may lead to negative outcomes, because lawyers who decide on the language used may distance marginalized populations who may not understand the law discourse. Although the human rights framework has emphasized disability issues, disabled people are not a homogenous group and solutions should not be based on the principle, that one size fits all (Katsui, 2008). Katsui noted that this diversity and the elimination of barriers cannot be dismissed if the rights of disabled people are to be recognized; in order to change discriminating contexts, political action is required to address the current power and dominance structure in society. In some cases, disability intersects with poverty therefore, basic human rights, to needs such as food, clothes, shelter, and access to medications, first need to be met (Katsui).

Dupré (2012) proposed a social work cultural disability approach. The disability movement recognizes the existence of a disability culture; it evolved from the disability arts movement and it centers on the positive portrayal of disabled people (Dupré). The disability cultural approach is cross-cultural and includes art, humour, history, discourse, beliefs, values and ideas for surviving and thriving as a disabled person (Dupré). It differentiates between negative stereotypes of disabled people produced by dominant society and more positive images of difference (Dupré). This same author noted that social work cultural practices signify an attempt to overcome oppression (Dupré). It is a practice approach that acknowledges and accepts cultural differences between services providers and service users (Dupré). Cross-cultural social work is practiced in a context, in which the social worker and the service user from different cultures (disability culture and social work culture) negotiate and communicate, to co-construct new relationships and meanings (Dupré). Knowledge of the service user's culture and cultural

politics are required in order to understand the dynamics of difference, avoid misinterpretations, and support disabled people in the deconstruction of the norms and dominant discourses (Dupré).

A trend in the United Kingdom and more recently in Canada, are disability approaches that focus on individual self-assessment and self-directed social welfare services (Harris & Roulstone, 2011). This means that social welfare services are moving towards more enabling provisions and the autonomy of disabled people; for instance, direct payments and self-directed budgets, personalization of care, and the active involvement of disabled individuals in service reviews (Harris & Roulstone). It is possible to argue that the rationale for the introduction of these practices is to shift power and decision making towards disabled clients; however, the main reason is more likely to cut government spending (Harris & Roulstone). The involvement of disabled people is based on their abilities and may occur in conjunction with proxies (e.g., family, social workers or helpers) (Harris & Roulstone). Some social workers and other professionals hesitate to adopt these less oppressive measures, because they fear that some disabled people could become more vulnerable and exploitable, the personalization of services could cost more, or disabled people might ask for services that are questionable or not available (Harris & Roulstone). Despite negative critiques, it is reasonable to suggest that disabled people's autonomy should be encouraged, in order to redistribute power away from professionals and into the hands of disabled people. Some disabled people have criticized the system for forcing them to find their own social welfare services, while others have been satisfied to finally achieve autonomy (Harris & Roulstone).

In Manitoba, many disabled people are still not able to live autonomous lives, even though the Manitoba Disabilities Issues Office (2001) White Paper stated that disabled people are full citizens, are provided income supports, access to government, disability supports,

employment, and are supposed to be offered social welfare services that are flexible, with the option of managing the delivery of these services, by the individual or family member (Manitoba Disabilities Issues Office, 2001). In this same document, environmental barriers were acknowledged as being disabling however, disabled people continued to be classified according to the medical model (Manitoba Disabilities Issues office, 2001). Lacking in this White Paper was the determination to change the fundamental ways that social welfare services and resources are being developed; more precisely, it failed to go beyond the acknowledgment of inaccessible environments.

More recently, the Manitoba Disabilities Issues Office (2015) has committed to the development and implementation of accessibility standards in employment (e.g., actively remove barriers to employment to raise the number of disabled people in the workforce), to the removal or prevention of social and structural barriers, compliance orders (e.g., enforced accessibility standards), to increased training, resources and public awareness of disability.

The profession of social work recognizes the usefulness of models such as the person-in-the-environment and anti-oppressive approaches (Pollack, 2004). Even though social workers have drawn on anti-oppressive approaches when working with marginalized populations of able-bodied women, like women in prisons, social work rarely articulates the use of a distinct practice model when working with disabled women who have been abused by their male partners (Pollack).

Central to anti-oppressive approaches is a commitment to shift discourses, relationships, and dominant systems that discriminate and oppress women (Pollack, 2004). For these reasons, it is possible to argue that an anti-oppressive approach that critiques non-disabled patriarchal systems and power relations would be appropriate when working with disabled women who have

experienced MPV. Compared with the medical model that does not necessarily shift discourses and does not aim to eliminate discrimination (Oliver & Bailey, 2002) or the person-in-the-environment perspective that might lack a focus, on physical environments that contribute to women's disability experiences (e.g., lack of accessibility), (Rogge & Cox, 2001), an anti-oppressive approach with disabled women who have been abused by their male partners could open a dialogue into power relations and discrimination. Anti-oppressive approaches might be valuable if they are in-line with independent living views that consider social workers as consultants of services; however, there is little in social work education that prepares workers to deal with oppressive systems (Wilson, 2013). Social workers are encouraged to advocate for vulnerable individuals but are typically, not taught how to proceed when systems and individuals refuse to give up their power (Wilson). Given this scenario, social workers who provide services to disabled women should be encouraged to challenge these systems in a positive manner, by shifting power away from authorities, into the hands of service users (Wilson).

Feminist disability theory is especially applicable to social workers who work with disabled women because it considers gender and disability to be socially constructed by mainstream society and provides evidence to explain how dominant society shapes our understanding of disability and male partner violence (Garland-Thomson, 2002).

This does not mean that it overlooks the *reality of individuals' lived experiences* (Garland-Thomson, 2002). Social construction "…takes the view that knowledge in some area is the product of our social practices and institutions…" (Young & Collin, 2003, p. 376).

[A] term used to describe…[a] way of thinking about knowledge… is that knowledge is socially constructed. When we refer to knowledge as socially constructed we mean that knowledge is reflective of the values and interests of those who produce it. (Sensoy & DiAngelo, 2012, p. 7).

In particular, feminist disability theory recognizes that dominant Western thought and institutions *socially construct disability as an individual issue* and shape how we understand *male partner violence*; more specifically, that the male partner in a patriarchal society is viewed as having power over his disabled female partner (Garland-Thomson, 2002). Feminist disability theory draws on the idea that a patriarchal society produces gender inequalities and a disabling society further oppresses disabled women, by perceiving disability as an individual 'defect or problem' (Garland-Thomson; Mays, 2006). Feminist disability theorists and writers like Garland-Thomson, Mays, Meekosha (1990) and Chenoweth (1996) noted that disabled women were at a greater risk for male partner violence compared to non-disabled women, because of their marginalization and being perceived as vulnerable and dependent, in today's patriarchal society. In order to advance this discussion, it is important to first acknowledge that there are multiple feminist interpretations (Allen, 2011; Freeman, 2002). While it may be important to differentiate between the orientations of feminist groups, Thompson (2001) pointed out that focusing on different interpretations only subdues the real issue of power in relationships.

Radical feminists such as Catharine MacKinnon (1987) argued they did not exclude any women's concerns and their focus was to find ways to dismantle the patriarchy. Liberal feminists such as Betty Friedan wanted to improve women's work and the economic state of families (Douglas, 2001). Socialist feminists such as Stella Browne believed that the oppression of women lied in the unequal access to financial resources, societal structures and cultural

oppression (Bell & Klein, 1996; Rowbotham, 1977). Postcolonial feminists such as Chandra Talpade Mohanty (2003) focused on intersectional analysis that included race, nation, colonialism, sexuality, class and gender; however, critical feminists like Butler and Grosz found fault with postmodern philosophies that did not take into account the physical body and its differences (as cited in Jaggar & Young, 1999).

More recently, Weiss (2015) added to Garland-Thomson's (2011) feminist disability framework by examining how the female disabled body is situated in the environment. Weiss (2015) argued that disability cannot be located solely in the body or solely in the environment because it is best understood as being situated somewhere between the two. Weiss explained that some bodies fit better in some spaces than other spaces and every person has at some point experienced the feeling of fitting in or not fitting in. This perspective remains valid even when the environment is accessible; in other words, the disabled female body still exists even when it fits in the social or physical environments (Weiss). For instance, the environment may be entirely accessible to a disabled woman who uses a wheelchair, but this accessibility does not change the fact that she has a physical impairment (Weiss).

Feminist disability theory is not just about disability topics discussed in the literature such as illness, health, genetics, eugenics, aging, reproductive technologies, prosthetics, and access barriers (Garland-Thomson, 2002; Hall, 2011). Feminist disability theory attends to feminist topics such as the politics of appearance (Garland-Thomson). More precisely, when a disabled person appears 'physically normal', the more accepted he/she will be, by mainstream society (Garland-Thomson).

Feminist disability theory also examines how media and film portray disability (Chivers & Markotic, 2010). As such, disabled women in films tend to be portrayed as vulnerable,

undesirable, or unstable, instead of being viewed as independent, stable and strong (Chivers &

Markotic; Saxton et al., 2001). This feminist disability theory acknowledges that the disabled

body is frequently medicalized (e.g., perceived as ill and flawed) (Garland-Thomson, 2002) and

the formation of the disabled identity may be related to the inaccessible physical environment,

the individual's impairment, and society's attitudes (Shakespeare, 2006; Titchkosky & Michalko,

2009). Lastly, feminist disability theory emphasizes power relations, in particular, how disabled

women are disempowered by their male partner abusers and how there are a greater number of

disabled women who are likely to be abused by their male partners, than men abused by their

female partners (Garland-Thomson; Mays, 2006). Power relations are also evident in the social

worker and client relationship and for this reason:

> Social workers should be ever vigilant of the potential abuses of power inherent in their
>
> positions and the inevitability of their biases, distorted perceptions, and lapses into
>
> positions of therapeutic certainty. (Bransford, 2011, p. 40)

Bransford's (2011) recognition of power between a social worker and a client applies to this

current study and suggests that social workers who work with disabled women should be aware

that their biases may affect how they deliver social services (e.g., may focus on impairment

instead of male partner violence) therefore, they should work to minimize this influence; in

particular, "…if clients are to become empowered, workers must shed some of their [own]

power" (p. 36).

Furthermore, Garland-Thomson (2002) suggested that the integration of disability as a

category in feminist theory deepens the analyses of women as human beings. She proposed that

the inclusion of disability challenges the notion of what it means to be human and what it means

to be a 'normal woman' (Garland-Thomson).

Garland-Thomson said:

[The integration of] disability into feminist theory is generative, broadening our

collective inquiries, questioning our assumptions, and contributing to feminism's

intersectionality. Introducing a disability analysis does not narrow the inquiry, limit the

focus to only women with disabilities, or preclude engaging other manifestations of

feminisms. Indeed, the multiplicity of foci we now call feminisms is not a group of

fragmented, competing subfields, but rather a vibrant, complex conversation. (p.4)

What Garland-Thomson (2002) is saying is that the inclusion of disability is not about restricting

the feminist focus to disability; instead, it is about including disability concerns in the feminist

agenda. When applied to this study, it means taking into consideration disabled women's more

complex experiences of MPV. Although a feminist disability theory is inimitable when analyzing

disability and gender, in order to build on this framework, in this inquiry, critical theory is

essential.

Critical Theory

Critical theory is in line with social work's professional values of enhancing people's

wellbeing and the promotion of social justice in marginalized populations (Moya Salas, Sen, &

Segal, 2010). For instance, Hiranandani (2005) proposed that social work needs to apply critical

theory to question the perception that impairment is always a personal tragedy and to recognize

that individual inadequacy is socially reproduced. Indeed, social workers should not assume that

all disabled women consider their disability to be a negative experience (Hiranandani).

Individuals who are deaf, do not always consider themselves to be disabled, in fact, "…their

perspective consists of a cultural understanding of being in the world" (Delich, 2014, p. 319). In

other words, the Deaf community is a minority population with its own language and culture

(Delich, 2014). With this in mind, a critical theory of disability applied to social work research, such as this current inquiry, supports a closer interrogation of the meaning that has been assigned to disability (Hiranandani). It was important to examine social workers' definitions of disability and to determine if these were in line with disability organizations that view disability as being located in the environment or if their definitions of disability reflected a more medicalized view of disability that it is an individual deficit. After all, the participants' understanding and definitions of disability could have influenced how they related to disabled women and how they met their needs (Westhues & Wharf, 2012).

Foucault, Butler and Derrida's arguments about knowledge and power have inspired contemporary critical theorists to question the notions of disability and normality (Vehmas & Watson, 2014). For instance, Vehmas and Watson explained that critical disability theory has attempted to identify the differences that are used to maintain the hierarchies between disabled and non-disabled people. One example is that disabled people are perceived as being less capable when, in reality, it is the inaccessible environment and stigmatizing attitudes from mainstream society that are dis-abling (Shakespeare, 2006). Vehmas and Watson have suggested that the work of critical disability theorists should be to challenge meanings of disability and present problems that disabled people face as coming from the relationship, between disability and oppression. Yet, these same authors have questioned critical disability theory as being limited because it makes particular judgements about our current understanding of disabilities and social arrangements but like the social model that considers disability to be located in the environment, it offers little on the implications of living with impairments (Oliver, 2009; Vehmas & Watson). Vehmas and Watson argued that being free from ableist assumptions may not be enough because part of disability experiences may include pain or moral decisions (e.g., end of life decisions).

Despite these critiques, critical disability theory, like the social model, is considered vastly different than social work's *dominant* view of disability, that it is an individual problem that should be fixed (Hiranandani, 2005). In light of this dominant view of disability, Hiranandani expressed support for social work's interest in moving towards a critical theory of disability.

Meekosha and Dowse (2007) added to this argument by saying that the application of critical disability theory has shed light on social work's gatekeeping obligations with respect to disabled people; in particular, how the government is obligating social workers to determine disabled people's eligibility for resources (Meekosha & Dowse). These same authors also put forth the idea that social workers are not just policing disabled people's access to resources but are challenging the oppressive ways that governments are determining the eligibility for benefits by supporting disabled people's right to autonomy and to manage their own needs (Meekosha & Dowse).

Fook (2003) argued that the critical foundation in social work, likely originated with radical critiques by Bailey and Brake (1975), Corrigan and Leonard (1978) in the United Kingdom, Galper (1980) in the United States, and in Australia by Throssell (1975), Rees (1991), De Maria (1993) and Fook (1993). In Canada, Moreau (1979) and Mullaly (1997) advanced a similar critical approach by emphasizing structural issues (Fook, 2003). For example, Fook (2003) remarked that the key concern with social structure is not blaming the individual for their disability and this is the foundation for radical, critical, feminist and structuralist approaches.

Epistemology and Critical Theory

Modern critical thought began in the early days of educational philosophy and the Western tradition and originated 2500 years ago in Greece (Siegel, 2010). While the term

'critical thinking' is relatively new, tenets such as 'levelheadedness' and 'cultivating reason'

have been regarded as fundamental principles, by educational philosophers (Siegel, 2010).

Critical thinking involves skills and abilities that are used to assess complex ideas and make

judgements while, critical theory is an approach that is used to explore the power that underlies

social conditions (Sensoy & DiAngelo, 2012; Siegel, 2010). It could be said that critical thinking

skills are necessary to apply critical theory. Key aspects of critical thought include the claim that

it relates to an 'ultimate standard', that it requires skills to reason and that it requires the ability

to make an assessment (Siegel, 2010).

　Critiques of the 'ultimate standard' or critical thinking suggest that it privileges the ideas

of dominant groups, it privileges reason over intuition, it may be directive instead of

collaborative, it neglects or downplays emotions, it deals in abstraction, and it assumes the

possibility of objectivity (Siegel, 2010). What critical thinking does is promote independent

thought and rational conclusions in thought and in action (Siegel, 2010).

A main distinction that was drawn by a first generation of critical theorists such as

Horkheimer was the difference in method between social theories, scientific theories, and

contemporary critical social theories; the first two categories were recognized as instances of

traditional theories, the latter represented the methodology that Horkheimer and the Frankfurt

School adopted (Corradetti, 2002). Horkheimer and his followers did not accept *objectivity* in

knowledge because they suggested that the purpose of knowledge was itself entrenched in an

historical and social process (Corradetti). Rationality, thus began to assume a double

significance: on the one hand, as recognized by German idealism, it was regarded as the primary

source of human freedom; on the other, it was conceived as the premise of authoritarianism

(Corradetti). Based on this evidence, it may be reasonable to say that critical theory as it is understood today, has undergone several reformulations (Corradetti).

Key Conceptualizations

The key elements of critical theory are challenging domination, social segregation, recognizing that relationships and structures are constructed as well as changeable, the emancipatory advantages of social action, and the recognition that knowledge may be related to dominance but in reality, it is socially created (Fook, 2003). This relatively new framework interrogates concepts such as social construction, materialist tenets, critiques of power, and the discourses of normalcy and measurement (Hiranandani, 2005).

The first concept, social construction or constructivism is predicated on "epistemological fallibalism" and it means that we are always lacking some knowledge and understanding; therefore, all knowledge is fallible (Cobern, 1993, p. 109). We never know for sure how close our knowledge approximates reality, hence we rely on significant interpretations of our experiences of reality (Cobern). The second concept materialism, holds that reality is physical and there is no spiritual or mental state that cannot be explained beyond what is considered to be a tangible substance (Larson, 2013). The third tenet, critiques of power delineates the idea that knowledge is power (Corradetti, 2002). Finally, the discourses of normalcy and measurement in reference to disability refer to the standard against which humans are measured and the notion that 'normalcy' is the only way to experience 'a good life' (Titchkosky & Michalko, 2009). "Categories of 'disability' and 'ability', 'abnormal' and 'normalcy' are rendered and *constructed* within discourses" (Cockain, 2014, p. 1481). More importantly, critical theory can be a guide to social change, calls for an investigation of the social order, and questions why collective needs go unmet while the existing power structure remains the same (Moya Salas, Sen, & Segal, 2010).

Although a feminist disability approach is valuable when analyzing dominant disability models and gender, in order to build on this framework, the addition of critical theory is essential. Critical theory is in line with social work's professional values of enhancing people's wellbeing and the promotion of social justice in marginalized populations (Moya Salas, Sen, & Segal, 2010). Critical theory that includes key elements such as constructivism, materialism, critiques of power, normalcy and measurement have focused this research inquiry. More specifically, feminist disability and critical theories were used as the lens to examine social workers' perspectives, practice contexts and work with disabled women who have experienced MPV.

In summary, theories and models that inform social workers' practices need to be re-examined to ensure that they are based on perspectives that support disabled women who have experienced MPV and their right to be autonomous and live in safe environments. Approaches such as feminist, critical or structural, that take into account disabled women's needs and acknowledge inaccessible environments may be valuable to social workers' practices with disabled women who have experienced MPV (Pollack, 2004; Wood & Tully, 2013).

The next chapter presents the qualitative method and describes the case study methodology used to gather data on social workers' practice context and experiences when they worked with disabled women who had experienced MPV. This current research is important because there is a lack of knowledge when it comes to social workers' experiences and their work with disabled women especially, when we consider what is beneficial and what could be improved.

Chapter Four – Research Design and Procedures

In order to access the type of in-depth and nuanced data required in this research, a qualitative perspective was found to be the most appropriate research approach. A qualitative design provided an opportunity to develop a more comprehensive picture of the topic under study (Creswell, 2007; Hartley & Muhit, 2003). Qualitative inquiry by its very nature, approaches the study of beliefs, attitudes and behaviors in a different way, than a quantitative approach (Creswell, 2007; Hartley & Muhit). Specifically, a qualitative approach employs the use of open-ended questions, within a contextual framework, that allows for a deeper exploration and understanding of participants' lived experiences (Creswell, 2007; Hartley & Muhit). Conversely, a quantitative approach often relies on closed-ended questions to generate results that are numerically comparable across the sample (Creswell, 2007; Hartley & Muhit). A qualitative approach is especially useful whenever there is a lack of research in a particular area (Creswell, 2007; Hartley & Muhit) such as social workers' perspectives and experiences when working with disabled women who have been abused by their male partners. Unlike a quantitative approach, the strength of a qualitative design lies in the fact that it includes a wide range of views, it is flexible and uses clear inclusion and exclusion criteria, to select participants (Creswell, 2007; Hartley & Muhit).

According to Creswell (2007), one type of qualitative methodology is case study research; it may focus on one case or on collective cases to explore a particular phenomenon. Case studies typically include a small number of participants, acknowledge real-life contexts, are not generalizable, include multiple sources of evidence and may be used to explain individuals' behaviors within specific contexts (Gerring, 2007). The most applicable case study approach, for this current research was a collective case study (Creswell, 2007; Hartley & Muhit, 2003; Stake,

2006) because this inquiry involved the examination of social workers' perspectives, experiences and practice contexts with any disabled women who had been abused by their male partners.

> Case studies [are valuable in social work research because these] show how individuals interpret and apply the mandates of public policy to the individualized situations in which they operate. The processes of and barriers to implementation, including contextual features and characteristics of both implementers and subjects of the implementation, can be investigated through case studies (Gilgun, 1994, p. 375).

There are two main collective case approaches; one was advanced by Stake (1995) and the other by Yin, (2003). Yin's approach is somewhat different from Stake's approach as it suggests that the examination of cases may be used for theory building, while Stake argues that cases should be used to study phenomena. In this current study, the collective case study approach as described by Stake (2006) informed my methodology and was useful in garnering an in-depth understanding of social workers' perspectives, their practice contexts and their experiences when they worked with disabled women who had been abused by their male partners. Developing theory on this subject matter was beyond the scope, of this thesis. When a collective case study follows a qualitative framework, such as this current inquiry, it is based on a constructivist perspective (Stake; Yin). A constructivist endeavour acknowledges that truth is relative and subjective because it relies on one's perspective (Baxter & Jack, 2008). According to both Stake (2006) and Yin (2003), a collective case study is appropriate when you are trying to answer 'how' and 'why' questions. Stake recommended four to ten cases per study in order to access in-depth data. Stake (2006, p. 12) remarked that more than ten cases could lead to "…more uniqueness of interactivity than…readers could understand".

Furthermore, collective case studies are particularly helpful when exploring the significance of contextual factors and the interaction between the case and context (Stake, 2006). For example, I wanted to understand social workers' experiences when they worked with disabled women who had experienced MPV and the possible influence of contextual elements. Social workers are employed in various practice settings such as healthcare services, child and family agencies, crisis clinics, addiction agencies, and other settings; therefore, it would have been difficult to obtain a true representation of social workers' experiences when they worked with disabled women, without considering their various individual workplaces. Social work participants described their experiences and practice contexts in response to questions that I asked. The research instrument that guided my conversations with social workers is included in Appendix B.

The unit of analysis in collective case studies can vary "...from individuals to a corporation" (Zucker, 2009, p. 1). Collective cases facilitate the exploration of experiences, perspectives, or phenomena (Baxter & Jack, 2008; Creswell, 2007; Stake, 2006). The unit of analysis or "quintain" (Stake, 2006, p.3) is what we seek to understand and in this study, the quintain was social workers' experiences including practice contexts, when they worked with any disabled women who had been abused by their male partners. Baxter and Jack criticized Stake (2006) for failing to deliver a clear conceptual framework that would provide a better understanding of influences that could affect the quintain. These same authors cited Miles and Huberman (1994) who suggested a framework that could be used to better interpret data (Baxter & Jack).

Miles and Huberman (1994) stated that relationships could exist between contextual factors and that displays could be used to present this data. "A display is an organized,

compressed assembly of information that permits conclusion drawing and action…looking at displays helps us to understand what is happening and to do something…either analyze further or take action…based on that understanding" (Miles & Huberman, 1994, p. 11). Miles and Huberman noted that the display format or illustration could include various shapes, phrases and arrows and it depended on what a researcher was trying to understand; for instance, the researcher could be trying to illustrate a general situation or the interplay of conceptual variables.

The Current Study's Methodology

Miles and Huberman's illustrative frameworks (1994) were valuable in the development of my own contextual diagram (Figure 1), by serving as an inspiration to this study's collective case research. This current diagram illustrates the contexts that shaped social workers' experiences when they worked with disabled women who had experienced MPV. In this diagram, the defined context is the environment as it was understood by each participant, to have influenced their experiences when working with disabled women who had experienced MPV.

In this study's contextual diagram, squares represent *external* or *broader influences* such as federal or provincial government programs, policies, mandates and legislation, influence from other professionals and barriers or resources that social workers identified, when attempting to meet the needs of disabled women who had experienced MPV. Circles represent the *internal* or more *specific influences* that social workers recognized as characterizing their individual practice context, such as years of experience as a social worker, specialized training or education received in partner violence or disability, work setting and attitude towards helping or advocating for disabled women who had experienced MPV. Arrows represent the possible reciprocal relationships between the external and internal influences.

The various aspects included in this study's diagram are similar to those found in Cameron and King Keenan's (2007) stressed the importance of factors that had impacted social workers' practices. Factors identified in that particular study were derived from research on direct practice; these factors included government legislation, policies, environmental barriers, education, type of service provided, the time frame and work procedures (Cameron & King Keenan). Cameron and King Keenan stated the importance of model that could provide social workers with a list of factors that had been shown to be effective in direct practices.

F*igure 1*. Contextual Diagram Based on Milesi and Huberman (1994). This figure illustrates exterior and interior contextual elements that were identified by social workers.
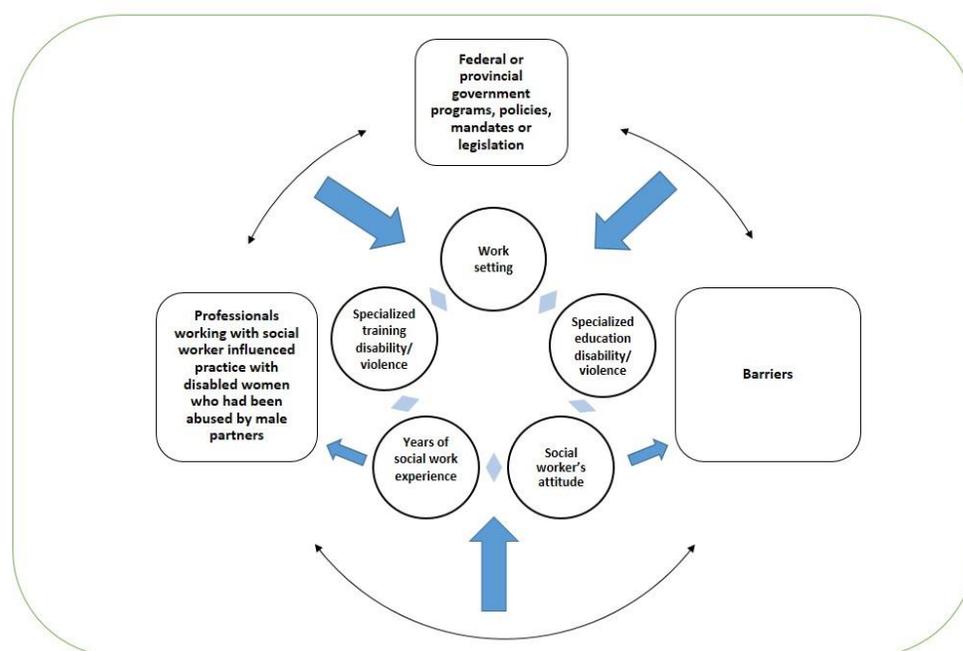
Of interest was that Cameron and King Keenan (2007) suggested that personal characteristics involving culture, spirituality and religion could profoundly impact social workers' practices however, their effects were not necessarily known therefore, were not part of this research.

The contextual elements identified in this diagram are not exhaustive and contain limitations. For instance, in my diagram, it was not possible to include social workers' or service users' personal characteristics (e.g., ethnicity, religion, culture) that may also have contributed to the context. In this study, the sampling strategy focused on a cohort of social workers who had worked with any disabled and abused women between the 1980s and the present day.

It is also important to note that contextual elements often interacted with each other. Exterior elements could affect interior elements, such as a government policy affecting an individual social worker's workplace. Interior elements could also affect one another, such as a social worker's attitude that changed as a result of disability or partner violence education. Less often, an interior element could impact an exterior element, such as a social worker's attitude, could lead him/her to advocate for disabled women to policy makers. Critically important is the fact that these experiences were acknowledged and explored but it was not possible to generate an exhaustive list of all influential elements. Participants' descriptions of contexts were of elements they believed had influenced their experiences with disabled women who had experienced MPV and were not meant to represent all influences, over their whole careers.

Stake (2006) argued that each case is located in its own context and in this current study, the diagrams served to illustrate the contexts that had potentially influenced social workers' experiences when they worked with disabled women. Stake's collective case approach informed the cross-case analysis in this study. Meaningful patterns that were derived from the cross-case analysis were labeled as categories and from these categories, themes related to the interview questions were identified. Contextual elements provided an illustrative framework for participants' responses to the interview questions that were examined in the thematic cross-case analyses.

Ethics and Procedures.

Research ethics approval was obtained before the study was undertaken (Appendix B), and a call for social workers to participate in this qualitative research inquiry was sent by email, in Winnipeg and across provinces through various social workers' associations, disability organizations, and schools of social work. I did not approach social workers myself in order to avoid the perception of coercive recruitment.

A strategy of purposive sampling (Stake, 2006) was used, whereby, social workers who had worked with disabled women who had experienced MPV were recruited through third party sources. Stake stated that being able to bind the case or set boundaries was important to ensure that the research focus was explicit and the quintain identified. As mentioned, in this study, the boundaries were set around a cohort of social workers who were working with women, who had any type of disability and who had been abused by their male partners and social workers were not asked to distinguish between their experiences when they worked with disabled women and various intersections such as Indigenous disabled women, immigrant disabled women, elderly disabled women or types of disability, as this would have changed the research focus (quintain).

Data Collection.

In this study, after receiving written consent by email, 10 social workers who had worked with disabled women who had experienced MPV participated in face-to-face interviews in Winnipeg or by a long-distance telephone interview, if they lived out of the province. When beginning this research, the goal was to conduct ten face-to-face interviews in Winnipeg however, a poor response rate resulted in having to expand my search for participants across Canada and to conduct more telephone, than face-to-face interviews.

I had concern telephone interviews could be problematic as it is widely reported that rapport can be more difficult to develop over the telephone which could affect the quality of the responses (Irvine, Drew, & Sainsbury, 2013). Contrasting evidence showed that interviews over the telephone tended to produce reliable data because interviewees found alternative ways to cope with the lack of face-to-face interaction and rapport (Irvin et al.). For instance, participants who were interviewed by telephone tended to check in more with the interviewer to clarify their statements, while the interviewer was less likely to interrupt and talked less than the participants; perhaps explaining the reason that telephone interviews tended to be shorter (Irvin et al.).

In this study, the majority of social workers said that they felt more comfortable talking on the phone, rather than face-to-face because it afforded them the opportunity to be more anonymous and to discuss sensitive viewpoints. Each social worker received a ten dollar gift card by email. Participants were interviewed in their places of work, at home, or at a university location, at a time of their choosing. When conducting telephone interviews, I asked the participants if I could put them on speaker phone, to facilitate the recording of conversations. All participants agreed to this and the sound quality was good except, in two instances. In one case, I had to ask the social worker to speak louder and in the other instance, the social worker had to change locations because of poor cellular reception. One social worker decided to change location during the interview and moved to a private office, because the interview was being conducted at work. In some instances, participants strayed away from the questions that were posed and I had to repeat the questions or probe further to focus their responses or ask them to elaborate on what they meant, in order to make sure that I understood what they were saying and not simply rely on my assumptions, of what I thought they said. In some cases, participants discussed certain practice models that they tended to use with disabled women however,

additional probing on my part could have resulted in participants' revealing particular theories that had shaped their practices with disabled women. All participants said that they wanted to receive a summary of the findings and this will be sent to them at the end of the research study.

Each social worker was asked a series of open-ended questions and was given the opportunity to comment further. Interviews lasted between 60 and 120 minutes. One participant was contacted a second time by email and was asked to clarify what social work theory or model she had used in her practice with disabled women who had experienced MPV. All interviews were transcribed verbatim as I went along, took about 20 hours to transcribe and generated over 200 pages of transcripts. The digital recorder that I used had a pause and playback feature that allowed me to listen to interview sections as many times as required, to make sure that the transcripts were correct. I listened to the recorded interviews multiple times, reread all of the transcripts numerous times, throughout the analysis process and noted nuances in the conversations, before starting the analysis.

I assigned fictitious names to each participant for purposes of confidentiality. The recorded participant interviews and subsequent transcripts were secured on a password protected laptop and two of the transcriptions were shared with my advisor. Securing the data physically was another way to safeguard participants' information. Several techniques were used to increase the rigour and quality of this research study.

Data Analysis.

Stake (2006) mentioned that the "data from a [collective] case study usually will come mostly from the cases studied..." (p.15). For example, the data in this study was derived from interviews and a thematic analysis of the interview transcripts was conducted; transcripts were read and reread and analyzed using Stake's coding technique to conduct content analysis. Stake's

system of worksheets (Table 1) provided the framework for the analysis. On the first worksheet, Stake proposed that a researcher should write a description of the case he\she is studying; in this study, it was a description of each social worker's interview such as the setting and social workers' experiences related to disabled women who had been abused by their male partners.

Ten number one worksheets were completed, one for each participant's interview. On the second worksheet, I entered the responses to each interview question and a unique identifier that represented each case (e.g., Lee works in healthcare). On the third worksheet, I included my notes that I kept on observations, questions, reflexive thoughts and ideas.

Table 1

Worksheets as based on Stake's framework used to analyse participants' transcripts

Worksheet number one	Description of social worker's interview – one sheet for each case
Worksheet number two	Responses to interview questions – one worksheet for each social worker including writing an identifier that made the case unique (e.g., had more than one workplace)
Worksheet number three	Process notes
Worksheet number four	How each response to the interview question was reflected in each case; the meaning or first level of themes
Worksheet number five	Merged themes
Worksheet number six	Similarities and differences between cases

These notes were like my research process journal, that I referred to and I would go back and forth between the transcripts and my notes. The fourth worksheet, I filled out to reflect the applicability of the case in relation to each interview question; for instance, how well did social workers define disability, were these clear definitions or did they choose not to answer certain

questions, were their responses similar to each other or did they provide a unique meaning of disability, compared to the other participants?

Text assigned to these initial categories was continually compared to each other and secondary categories were identified. Next, categories were merged into themes that reflected the responses to the interview questions. Additional themes that were separate from the interview questions were identified. The fifth worksheet included assertions that were based on merged themes for example, in defining disability, particular themes were identified from the cases, such as 'disability is self-defined'. The sixth worksheet included collective case assertions such as similarities and differences between the cases (Stake, 2006). For example, in this study, social workers described their workplace settings as being generally different from one another but participants' perspectives on barriers that disabled women who had experienced MPV faced were similar.

Finally, critically analyzing data from participants' interviews by using triangulation as described above, with federal or provincial government reports, provincial social policies or statutes, and other academic literature, generated a deeper understanding of the findings and validated participants' words.

Quality of Research.

There are several fundamental elements that can enhance the rigor of qualitative studies (Baxter & Jack, 2008; Stake, 2006). For instance, Morse (2015, p. 1212) noted that Lincoln and Guba (1985) were first to "replace [the] terminology… reliability, validity and generalizability with trustworthiness consisting of dependability, credibility, transferability, and confirmability". Morse (2015) suggested that dependability could be achieved with an audit trail such as notes, credibility could be achieved with peer debriefing, prolonged observations, triangulation,

member checking or peer review, while transferability could be achieved by including thick descriptions and finally, confirmability could be achieved by including triangulation and an audit trail. Morse (2015) agreed with Creswell (2007) who suggested that at least two of these elements should be included in a qualitative research study. In this study, dependability, credibility, transferability and confirmability were included in the research process.

To ensure the quality of this study, dependability was achieved with the use of notes throughout the inquiry. Using Stake's (2006) worksheets, I wrote process notes to provide accountability and transparency. Note writing was a way to be reflexive, minimize my biases, to make note of difficulties (e.g., finding an interview location for one participant) and to make sure that I was consistent when conducting the interviews (e.g., asking the same questions in the same order). I was able to use the process notes to reflect and be explicit about my bias as a social worker who had worked with disabled women, who had been abused by their male partners. Being reflexive also gave me the opportunity to be transparent about my biases and how these likely shaped this research study. Moreover, clarifying research bias is crucial so that the reader understands where the researcher is situated and outlines any biases that might impact the findings (Creswell, 2013). For instance, my bias became apparent when I noticed my hesitation in reporting negative findings. As a social worker, it was difficult to hear and to report evidence that portrayed other social workers in a poor light; however, I realized that omitting this data would only provide part of the story, therefore all findings were included. Creswell suggested that it is necessary to report all evidence in order to be certain that the phenomenon in question is portrayed in a realistic manner.

Next, credibility in this study was achieved with member checking. I emailed each participant their respective interview transcript and asked them to review them for accuracy and

to let me know if they had any questions. Four out of ten participants responded to my email. Three participants emailed back and after reviewing their transcripts were able to clarify certain words that had not been clearly understood over the telephone.

Creswell (2013) and Morse (2015) also suggested that external auditors who are not familiar with the topic could be consulted in order to establish credibility of the coded data. For this current study, I asked a graduate student from a different faculty to review the transcripts (names, cities and specific workplaces of participants were removed to ensure confidentiality) to see if she would come up with similar themes. This process confirmed that the themes she found were comparable to mine, suggesting the identified themes could be relied upon.

Creswell (2013) recommended that researchers use probing to attain rich, thick descriptions to allow readers to judge whether the findings are sincere. During the interview, I used probing to get the participants to elaborate and clarify what they meant to say. I also chose to include rich full quotes to make certain that the participants' words were accurate and complete and provided a description of social workers' practice contexts. For instance, social workers who work with disabled women who have experienced MPV are not necessarily a homogenous group, even though they share a common profession; they have different orientations, education, training and years of practice experience.

Confirmability in this study was achieved by using triangulation. Miles, Meijer, Verloop and Beijaard (2002, p. 146) outlined five kinds of triangulation in qualitative research that was proposed by Miles and Huberman (1994):

Triangulation by data source (data collected from different persons, or at

different times, or from different places), triangulation by method (observation,

interviews, documents, etc.), triangulation by researcher (comparable to interrater

reliability in quantitative methods, triangulation by theory using different theories, for

example, to explain results, triangulation by data type (e.g., combining quantitative and

qualitative data).

In this study, triangulation by research coders (more than one person uncovered similar

themes) and triangulation by method was used; documents such as provincial statutes, policies

and federal or provincial government reports and academic literature were used as independent

verification of participants' words. For instance, when participants mentioned that provincial

healthcare policies were restrictive because service users had to satisfy certain disability criteria

to obtain social welfare benefits, documents such as academic literature or provincial documents

were used to verity, that this was indeed the case.

Further recommendations by Creswell, (2007), Hartley and Muhit, (2003) and Stake,

(2006) were followed; these included research questions that were clearly written, a research

design that was appropriate for the questions, appropriate sampling methods were stated and data

that was collected, organized systematically and analyzed in a correct manner.

Reporting the Findings.

Baxter and Jack (2008) suggested that there is not one all-encompassing way to report

findings from a collective case study. Instead, Baxter and Jack said that researchers should focus

on specific contexts and describe the phenomenon in the best manner that fit the data. In this

current study, identifying contexts and themes were found to best represent the data from the

participants' interviews.

In summary, this chapter presented and explicated the case methodology and the technique used to interview participants and collect, analyze and present the data that provided insight into social workers' experiences when they worked with disabled women who had experienced MPV. In this study, the boundaries were set around a cohort of social workers who had worked with abused and disabled women during the 1980s to present day.

The next chapter 'findings' presents key qualitative data that were gathered from the interviews with social workers. Social workers' perspectives, contexts and work with disabled women who had experienced MPV are examined using the contextual framework that takes into account the interactions between external and internal contextual elements.

Chapter Five – Findings

This chapter presents the findings that were derived from the participants' interviews.

…Social workers have been increasingly reluctant to confront the political dimensions of

practice or challenge those forces whose values and goals run counter to their expressed

mission. Our definition of politics focuses on how power shapes the allocation of rights,

access, opportunities, status and resources—including workers' time, skills and

information. Situating political decisions in a…situational context would promote an

examination of the underlying assumptions and distributional effects of policies at all

levels, and their intended and unintended consequences (Reisch & Jani, 2012, pp. 1133-

1141).

Reisch and Jani (2012) are implying that the examination of contexts could provide a better

understanding of the allocation of resources, social workers' knowledge and the significance of

policies. Similarly, Stake (1995) stated that, "issues are not simple and clean, but intricately

wired to political, social, historical, and especially personal contexts. All these meanings are

important in studying cases" (p. 17). In a qualitative study, describing the context or environment

is key to understanding experiences and attitudes (Stake, 2006). These authors are implying that

the interview data that was used for the thematic analysis to answer questions about social

workers' perspectives and experiences when they worked with disabled women did not occur in

a void but in a specific practice context that must be taken into consideration, when examining

such cases.

In this study, contexts were examined and individual contextual diagrams were used to

exemplify both external (broader influences) and internal contextual (influences specific to

individual participants) elements. Contextual diagrams provide an illustration of the elements

that made up the contexts that arose from the participants' interviews. These contextual elements were not meant to represent all influences that could have been present throughout a social worker's whole career but served to anchor participants' descriptions of their experiences when they worked with disabled women who had experienced MPV. Various contexts demonstrated that similar and unique aspects influenced social workers' experiences when they worked with disabled women who had experienced MPV.

> [A] qualitative case study is an approach to research that facilitates exploration of a phenomenon within its context using a variety of data sources. This ensures that the issue is not explored through one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be revealed and understood (Baxter & Jack, 2008, p.544).

Participants were asked about their perspectives and definitions of disability and male partner violence and to identify theories or models. Participants' understanding of disability and male partner violence may have influenced how they met disabled women's needs.

In the first part of this chapter, demographics, participants' descriptions of their experiences when they worked with disabled women who had experienced MPV and contextual diagrams are presented. Participants were also asked to describe how government legislation, programs or mandates and work policies had influenced their work with disabled women and to talk about any barrier or resource they might have encountered when trying to meet the needs of disabled women who had been abused by their male partners. In the second part of this chapter, themes that were identified from the thematic analysis are outlined and discussed in relation to the literature.

Part One

Social Workers in This Study.

In this study, ten social workers, 9 women and one man who were working with disabled women who had experienced MPV were interviewed. Participants were from Prince Edward Island, Nova Scotia, Ontario, Saskatchewan, and Manitoba; five were practicing in a rural area and five had their practices in a city. Social workers from other Canadian provinces and territories were invited to take part in this study however, none responded to requests for participation.

Table 2 shows that participants were aged 26 to 65 years old, the average age was 52 years old and several social workers in this study worked in more than one field of social work practice. Participants had been working as social workers for an average of 20 years and on average, 19 of those years were spent working specifically, with disabled women who had been abused by their male partners.

Table 2

Characteristics of Social Workers' Employment

Employment Setting	Participants N = 10
Healthcare Services	4
Child and Family Services	3
Women's Shelter	2
Private Practice	3
Mental Health Services	2
Secondary Housing	1
Community Living	1
Addictions Program	1

Note. Participants worked in more than one field.

Six participants had been working in the social work field before receiving their social work degrees. The majority of social workers who were interviewed had a Master of Social Work degree, two participants had received some training in partner violence and four participants said they had received training in disability; however, none of the participants were

specific about their training except for Kelly who said that he had received mental health

sensitivity training at work. As seen in Table 3, five participants specified they had taken a

university social work course that included content on disability or partner violence issues.

Table 3

Participants' Work and Training Experience

Participants	Degree Obtained	Years Working with Disabled and Abused Women	Disability Training and/or Education	Partner Violence Training and/or Education
Emerson	BSW	2	No	Two-day workshop
Taylor	MSW	35	No	No
Riley	MSW	13	Community training/social work university course	Social work university course
Alex	MSW	35	Workplace mental health training	No
Lee	BSW	5	Social work university course	Social work university course
Mackenzie	MSW	3	Social work university course	Social work university course
Avery	BSW	32	No	Workplace Training
Kelly	MSW	15	Community mental health training	Social work university course
Chris	MSW	10	Workplace training	Social work university course
Jesse	MSW	35	No	No

In the following section, the focus is on individual practice contexts therefore, few

participant quotes are included in comparison to the thematic analysis. The practice contexts and

contextual diagrams illustrate how various elements may have influenced social workers'

experiences, when they worked with disabled women who had experienced MPV. The contexts

and themes are discussed in greater detail, in the summary and limitation sections.

Individual Cases

Lee's Practice Context.

Internal elements. Lee had a Bachelor of Social Work degree and as seen in Figure 2,

contextual influences mentioned by Lee, included internal elements such as working in a large

city in Manitoba and being employed in two separate departments in healthcare. Lee said that she

was part of a large team of healthcare professionals that included physicians, nurses,

physiotherapists and occupational therapists. Lee implied that there was a culture in healthcare

that promoted the medical model. Although she was aware of the medical model, she did not

necessarily agree with it.

> The medical model has become like med providers, you have a pain so here is a pill, you
> know to cure you, and sometimes what people need is to be listened to be understood.

Lee talked about additional internal elements, such as having worked as a social worker for 13

years, completing social work university courses that included some content on partner violence

and disability, but having no specialized training in partner violence or disability. A final internal

element identified by Lee was a desire to advocate for disabled women when she believed that

they were treated unfairly by the system (ethical decision). Lee said that she connected with

outside resources such as women's shelters when disabled women needed a safe place to stay,

wrote letters to Manitoba Members of Parliament and other associations, when disabled women

were denied social services or other benefits, for not fitting the disability criteria

> I wrote to everyone, I connected, I called directors, I called the stroke recovery
> association, I kept connecting with everybody. I wrote [to] MPs, I wrote every night, we
> had people with disabilities, who had been denied CPP disability and I wrote to our MP,
> their MP and I sent them the right information for physio or whatever [was required so
> they would receive the benefits].

Figure 2. Lee's contextual diagram. This figure shows influential elements in this social

worker's practice context when she worked with disabled women who had experienced MPV.
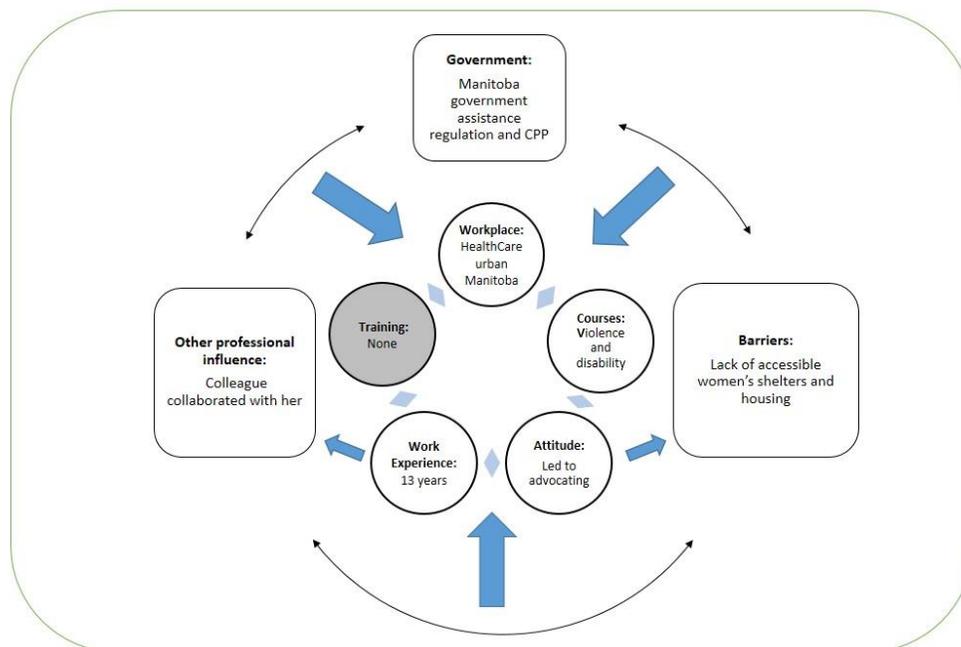
External elements. Lee also mentioned external elements that could be considered part of

the political context, such as the Manitoba Government's Assistance Regulation (based on the

Manitoba Assistance Act) and the Canada Pension Plan Act that was used to identify who could

obtain social services and other benefits. Lee said that these government regulations were often

too restrictive because some disabled women did not fit the disability criteria. A second external

element recalled by Lee was collaborating with a physician who alerted police authorities about a

disabled woman, who was being abused by her male partner. Finally, a third external element

included barriers encountered by Lee when trying to obtain services for disabled women, such as

a lack of accessible housing and women's shelters for disabled women. Lee said she could not

believe that shelters were not accessible and was concerned for what it meant to disabled women, she was working with.

> I was calling shelters and [they didn't] have accessibility for someone in a power wheelchair, because they are very big…I couldn't believe it myself and I was feeling very concerned and I can't imagine how she was feeling…and she was a very strong lady… although she was going through all that.

According to the Manitoba Standards Manual for Women's Shelters (Manitoba Government Department of Community and Family Services, 2014), shelters in Manitoba had at least one accessible room or women could be accommodated in a motel or hotel. However, this manual did not describe what was meant by accessible and it is possible that the room was not big enough to accommodate bigger wheelchairs, as mentioned by Lee.

Chris's Practice Context.

Internal elements. Chris had a Master of Social Work degree and as seen in Figure 3, contextual influences mentioned by Chris, included internal elements such as working in a large city, in Saskatchewan and being employed for a child and family agency. Additional internal elements included 13 years of social work experience, workplace training in disability (did not specify type), having taken a social work university course with content on partner violence and a willingness to protect and support disabled women's rights (ethical decision).

> It's a tough situation, [disabled women] have a right to live where they want, even if we think it's not the best situation and they are putting up with abuses. They have the right to have children, even and we have to support that right, with the ability to make good decisions.

Figure 3. Chris's contextual diagram. This figure shows influential elements in this social

worker's practice context when she worked with disabled women who had experienced MPV.
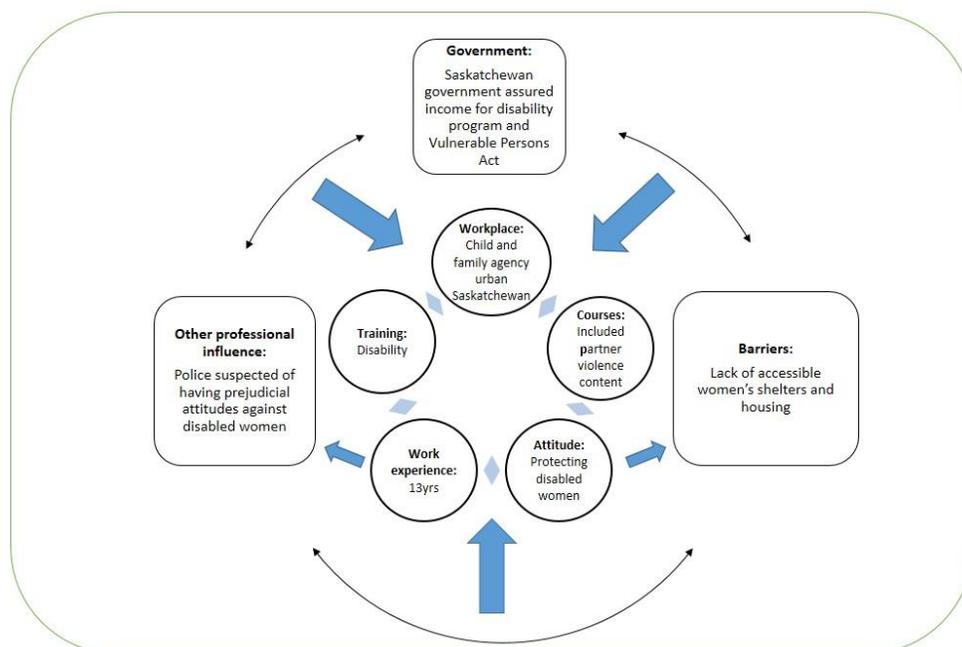
External elements. Other influences mentioned by Chris included external elements that

could be considered part of the political context such as a lack of accessible women's shelters

and housing and the Saskatchewan Government's Assured Income for Disability Program (based

on the Saskatchewan's Assistance Act) that determined the disability criteria used to identify

who could obtain social services. A final external element was Vulnerable Persons under The

Public Guardian and Trustee of Saskatchewan; in particular, that any suspicions of abuse of a

disabled woman had to be reported to police, even though, Chris said it seemed that police were

often prejudicial, because they did not always believe disabled women's abuse reports (culture of

prejudice towards disabled women who had experienced MPV).

> It was a frustrating situation and it happened more than once, where the police would say,
> well this person is incapable of standing up in court… saying this, like they didn't believe
> her therefore, why pursue it.

Kelly's Practice Context.

Internal elements. Kelly had a Master of Social Work degree and as seen in Figure 4, influences included internal elements such as having worked as a social worker for 27 years, in a large city and rural area in Nova Scotia. Additional internal elements mentioned by Kelly included working in a mental health center, being a mental health sensitivity trainer of healthcare professionals and having completed a social work university course with content on partner violence. Kelly talked about another internal element; in particular, he stated having a desire to advocate for disabled women when they were denied services (ethical decision by Kelly).

Figure 4. Kelly's context diagram. This figure shows influential elements in this social worker's practice context when he worked with disabled women who had experienced MPV.
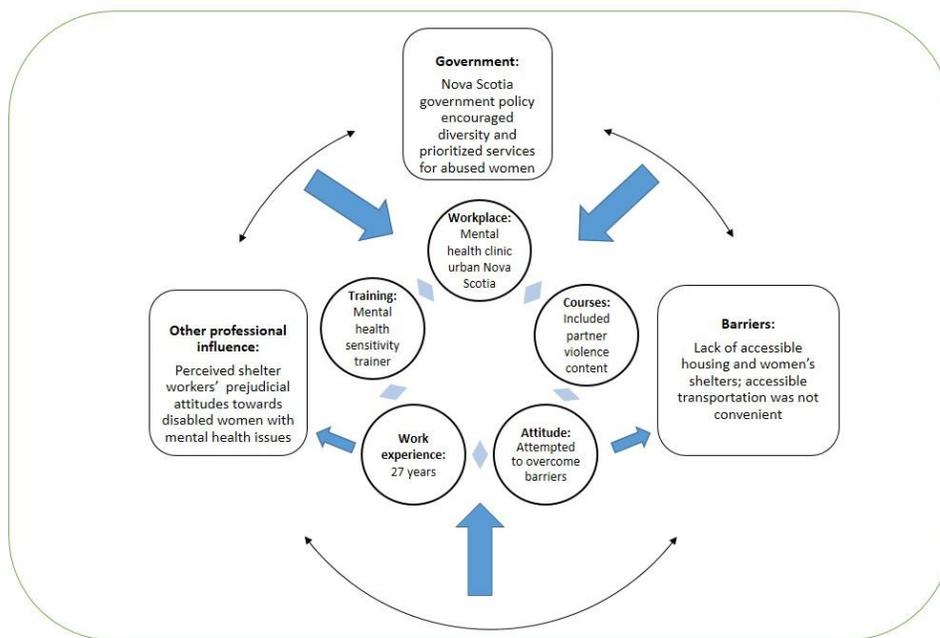

External elements. Other influences or external elements mentioned by Kelly included what could be considered part of the political context, the Nova Scotia Government's Healthcare Policy that promoted diversity, inclusion and cultural competence. Kelly said that this policy was helpful because it promoted the inclusion of all service users and social workers were expected

to respect service users' cultures. In contrast to this healthcare policy, the Nova Scotia

Government had a mandate to decrease partner violence and to prioritize housing for women

who had been abused by their partners; however, Kelly explained that there was no specific

prioritization of services for disabled women who had experienced MPV. Kelly talked about

other external elements such as an accessible bus that was not convenient, because disabled

service users had to wait hours for the return trip.

> I mean, she could go for an appointment but then that bus might not come back for two or three hours. It was only one [accessible] bus trying to service so many people, so she could be done her appointment in half an hour and then she had to wait and wait. What do you do if you have to go to the bathroom, so that kind of accessibility, I recall it being an issue and I felt badly for her and that's [why], I started to go to her home [to provide her with counselling], instead of her coming to my office.

He also said the social workers at the local women's shelter had not received any mental health

training. Kelly speculated that the shelter staff's prejudicial attitudes towards women with

schizophrenia and their lack of mental health training, might have explained their refusal to

provide shelter to a disabled woman, who had schizophrenia (culture of prejudice towards

disabled women with mental health issues).

> There was one woman who had schizophrenia and they asked her to leave because she took some scissors and cut her hair in a way that [shelter workers], thought that it showed that she wasn't stable. I thought that they were totally wrong, but that's what they did and I called and tried to intervene on her behalf, but to no avail and they asked her to leave.

Jesse's Practice Context.

Internal elements. Jesse had a Master of Social Work degree, and as seen in Figure 5,

influences included internal elements such as having worked as a social worker for 35 years, in a

large city and rural area, in Nova Scotia. Additional internal elements included working in

private practice and also in healthcare. Unlike the other participants, Jesse recalled doing

postgraduate studies in psychotherapy, but she had not received any specific training or taken any courses in disability or partner violence issues.

Figure 5. Jesse's contextual diagram. This figure shows influential elements in this social worker's practice context when she worked with disabled women who had experienced MPV.
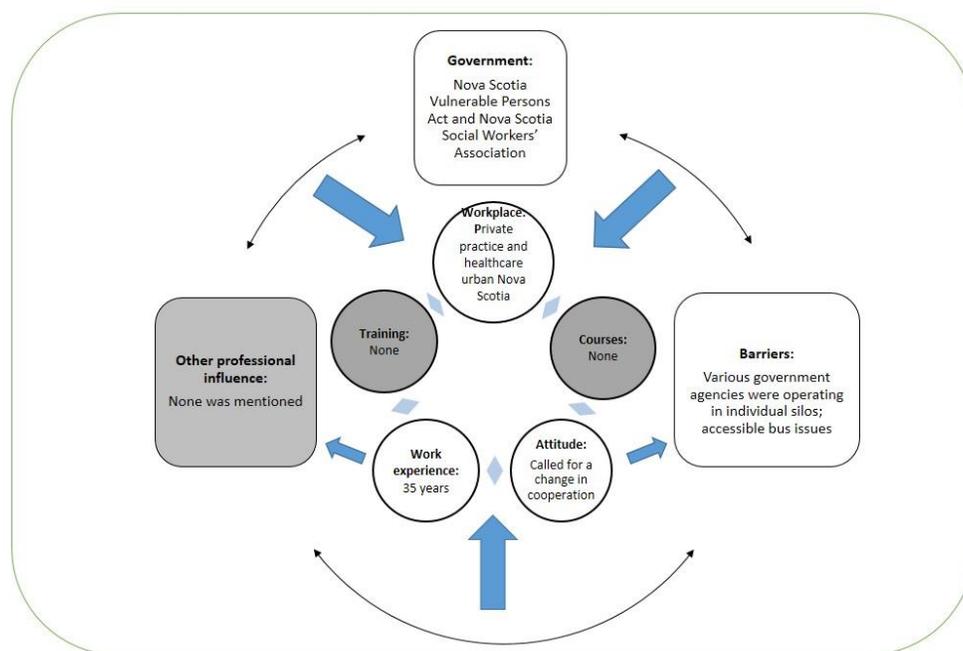
External elements. Other influences mentioned by Jesse included external elements that could be considered part of the political context, such as the Nova Scotia Social Workers' Association's model of care initiative, specifying that only evidence based theories could be used in a healthcare setting. Another external element mentioned by Jesse was the Nova Scotia Government's Vulnerable Person's Act, requiring her to call police, when there were suspicions of partner abuse of disabled women, who had "cognitive impairments" (participant's term). Although Jesse did not discuss other colleagues, as part of her practice context, an external contextual element that was highlighted as a barrier, was the lack of cooperation between various

agencies that provided services to disabled women. According to Jesse, there was a culture of non-collaboration between agencies, when it came to service users.

> The not for profit area that works specifically with domestic violence, I don't see them as having strong partnership with rehab or accessabus or the institute for the blind or with mental health services. They tend to work very much in silos.

> She also mentioned another barrier; in particular, a disabled woman who had to take into

consideration when she could book her appointments, because the accessabus was limited and

she could not bring her dependent child on the accessible bus.

> We do have an accessabus here, but this disabled woman had to make sure, that she could book all of her appointments, in the [limited time] the bus traveled and it had to co-ordinate with her work place. There were times when she had to accompany her son to medical appointments, but [he] was not permitted on the accessabus.

And finally, Jesse said that she could not advocate for disabled women who had been abused by their male partners, because her time was too limited.

Mackenzie's Practice Context.

Internal elements. Mackenzie had a Master of Social Work degree, and as seen in Figure 6, internal elements included having worked for 3 years as a social worker, in a rural women's shelter, in Prince Edward Island. Additional internal elements were the completion of social work university courses that had content on partner violence and disability issues; however, Mackenzie said that she did not have specialized training to work with disabled women who had experienced MPV.

Figure 6. Mackenzie's contextual diagram. This figure shows influential elements in this social

worker's practice context when she worked with disabled women who had experienced MPV.
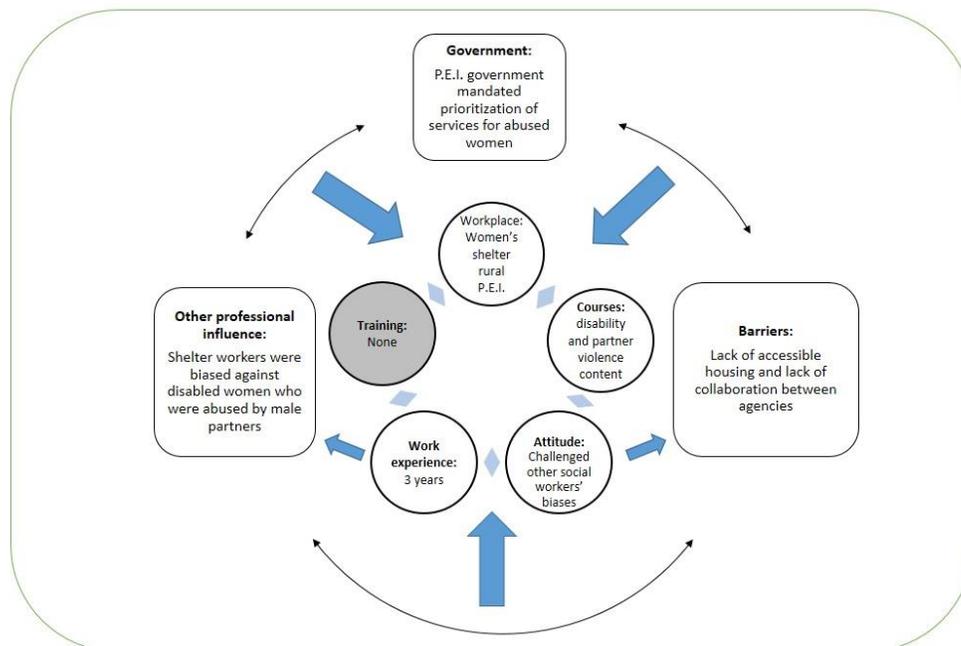
External elements. Mackenzie did reveal that she had challenged her social work

colleagues at the shelter, for what seemed to be a culture of prejudice. Mackenzie said that her

colleagues' attitudes were biased against disabled women.

> Shelter workers, they can be so jaded and when you try to challenge them on the
> assumption that they are making, they even justify their thinking. They say things like
> "well you know, you have to understand, when you've been in this field for as long as we
> have, you just know how cases are going to go. You just know that this person is not
> going to follow through". They would say yes, it's an assumption, but it's based on a lot
> of experience. I was thinking you're defending this, you're defending your position,
> you're making assumptions; negative assumptions about people and you're saying this is
> right.

Another external element mentioned by Mackenzie that could be considered part of a

political context was the Prince Edward Island Government's prioritization of housing for

women who had experienced MPV. This practice was not specific to disabled women and there

remained a lack of accessible housing for disabled women. Mackenzie implied that this policy

would have been helpful if accessible housing had been available.

> We have something called the PEI women's abuse protocol and it's the Provincial
> Government that is committed to removing barriers, to allow women to depart from an
> abusive relationship. A woman who experiences abuse goes to the top of the list, for
> many things… which is really helpful, when people are trying to leave or looking for
> housing. [This protocol] also extends to priority for housing, unfortunately, if you're on
> top of a list that doesn't move, it doesn't really matter, does it? There's no movement,
> which is often the case for housing.

An additional external element mentioned by Mackenzie was a culture of non-

collaboration between agencies. Social services agencies (e.g., income support and housing)

tended to work in separate silos, rather than working together to help disabled women who had

experienced MPV. She said that not working together caused frustration and the duplication of

services.

Avery's Practice Context.

Internal elements. Avery had a Bachelor of Social Work degree and as seen in Figure 7,

contextual influences included internal elements, such as having worked as a social worker for

over 30 years, in a rural area, in Nova Scotia. Avery stated that she did not have any specialized

education in disability or violence, she did not have specialized training in disability, but

mentioned that she had received some partner violence training at work (did not specify when or

what type). Avery had previously worked in a community setting, but at the time of the

interview, she was working part-time in private practice and also in healthcare. A final internal

element was Avery's desire to advocate for disabled women who had been abused by their male

partners (ethical decision).

> We were always trying to find a way around a policy, so that we could get the help that
> [disabled women] needed…I do remember having to write letters for those who had been
> denied benefits [because they did not fit the disability criteria].

Figure 7. Avery's contextual diagram. This figure shows influential elements in this social

worker's practice context when she worked with disabled women who had experienced MPV.
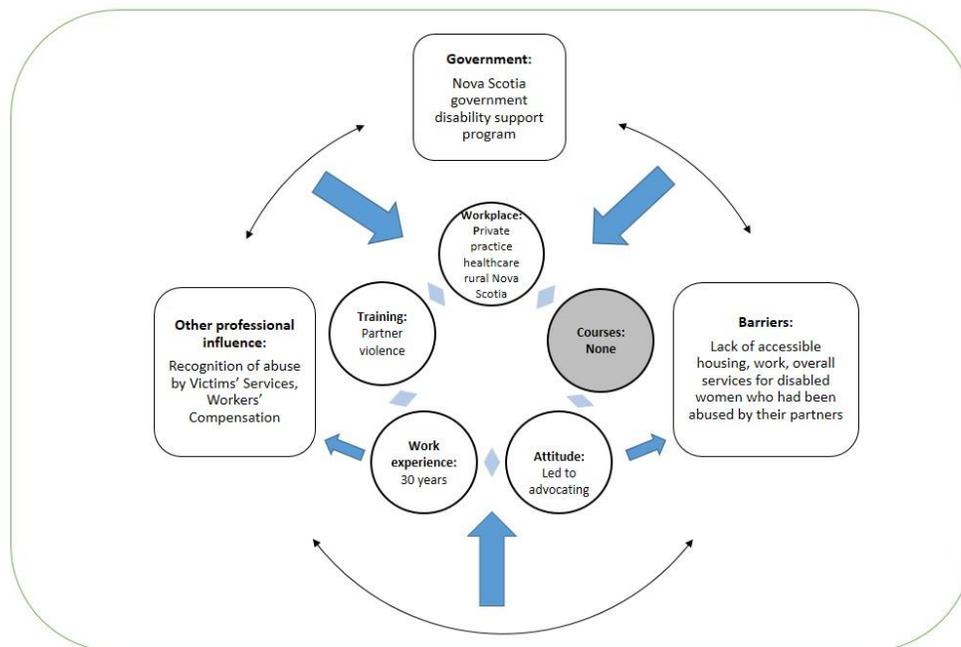
External elements. Avery mentioned an external influence that could be considered part

of the political context such as the Nova Scotia Government policies that were often not broad

enough to be of help. She said that the Nova Scotia Government's Disability Support Program

that was based on the Nova Scotia Assistance Act was limited, because this program tended to

exclude disabled women who did not fit the specific criteria, of being completely unemployable

and this limitation made it difficult for them to obtain financial support, to make their home

accessible.

> The Provincial Government certainly had more policies about what a disability was. You
> had to physically not be able to get into your house, in order to get financial assistance [to
> make your home accessible].

And a final external element mentioned by Avery was that other professionals were now

recognizing the effects of disability and abuse.

There is more recognition now at places like community services, victims' services criminal injuries… and Workers' compensation…There are other circumstances that render women disabled, it doesn't have to be physical limitation, there are life situations and life circumstances [such as abuse] that do bring upon disability in terms of stress, anxiety, and depression and so on there's more of a recognition now.

Emerson's Practice Context.

Internal elements. Emerson had a Bachelor of Social Work degree and as seen in Figure 8, internal elements included having worked as a social worker for three and a half years, for a family and child social agency, in rural Nova Scotia. Additional internal elements were having no training or education in disability but participating in a two day workshop, on the impact of partner violence. A final internal element was that Emerson frequently advocated for disabled women who had experienced MPV, by trying to obtain services for food and money because they tended to be poor (an ethical decision).

Figure 8. Emerson's contextual diagram. This figure shows influential elements in this social worker's practice context when she worked with disabled women who had experienced MPV.
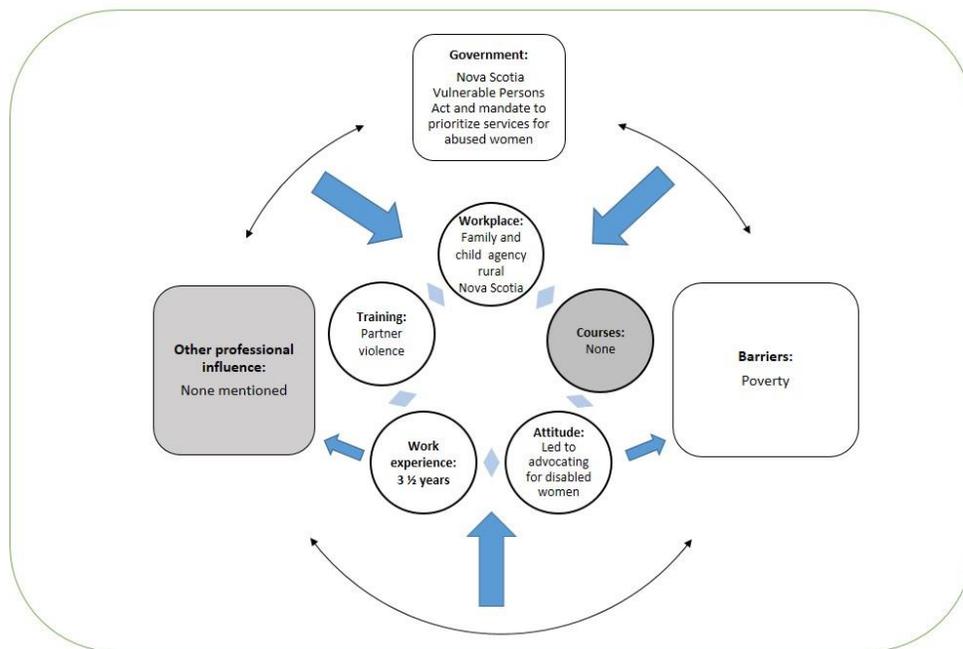
External elements. External elements that could be considered part of the political context included the Nova Scotia Vulnerable Persons Act that mandated her to call police, whenever she suspected any abuse of disabled women, who had "cognitive impairments" (participant's term). An additional external element was that the Nova Scotia Government (did not specify the department) had prioritized services for abused women however, it was not so specific, as to identify or prioritize disabled women who had been abused. Emerson said that social workers were having to work harder and to act quickly when it came to partner violence. Emerson added that abused women with cognitive issues did not know where to go for help and the abuse was often uncovered by a social worker who was working with them to address other concerns such as poverty. This social worker said that shorter response times were part of the government's effort to address partner violence.

> Recently, we have had a push in our province, for domestic violence…we've been very diligent to work with families, who are affected by domestic violence. For example, it used to be a 3 to 21day response, but lately it's been a 2-day response.

A final external element that could be considered a culture of non-collaboration was that Nova Scotia Government health agencies tended to work independently, instead of collaborating in order to help disabled women who had experienced MPV.

> Silos, yes...sometimes we didn't even know… so we got them… counselors and mental health [workers] and we didn't even know that they were already seeing the health agencies and in other cases we just duplicated services for family support workers.

Taylor's Practice Context.

Internal elements. Taylor had a Master of Social Work degree from the United States and as seen in Figure 9, contextual influences included internal elements, such as having worked as a social worker for over 40 years, in a large city, in Nova Scotia and not having any specialized education or training in disability or violence issues. This social worker remarked that 40 years ago, disability and partner violence issues were not typically discussed in social work courses. Taylor had worked for a secondary housing agency, in healthcare and was currently working in private practice. A final internal element was Taylor's desire to help and advocate for disabled women, by providing free counselling to them, when they could not afford it (ethical decision).

Figure 9. Taylor's contextual diagram. This figure shows influential elements in this social

worker's practice context when she worked with disabled women who had experienced MPV.
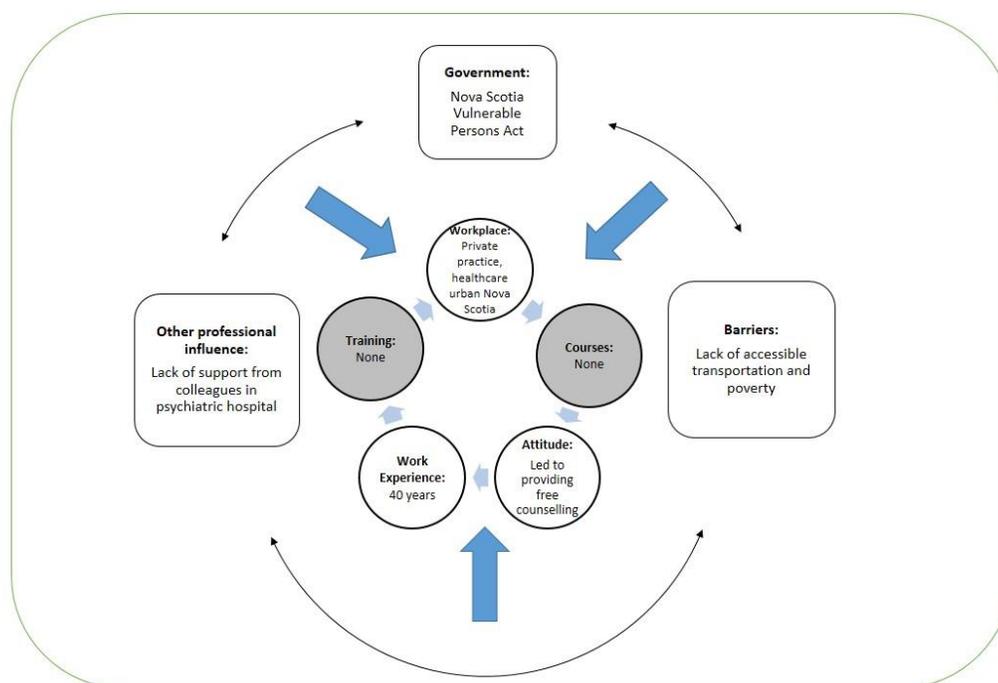
External elements. Like other participants in this study, part of the political context

included external elements such as the Nova Scotia Vulnerable Person's Act that mandated

Taylor to call police, whenever she suspected any abuse of disabled women, who had

"intellectual disabilities" (participant's term), when she worked for a secondary housing agency.

Additional external elements were barriers such as accessible transportation and the fact that

disabled women who had experienced MPV were often poor and could not afford the

transportation that was required to access other services, such as counselling. A final external

element was a culture of non-support in the healthcare setting that Taylor worked in.

> There was no support, no understanding, I mean, I was working in a mental health
> institution and I had said that I had concerns, but the psychiatrist didn't have to show up
> …that's something that stayed with me.

Alex's Practice Context.

Internal elements. Alex had a Master of Social Work degree and as seen in Figure 10, contextual influences included internal elements, such as having worked as a social worker for 35 years, for a family and child services agency, in private practice, and was at the time of the interview, working as an addictions counsellor, in rural Nova Scotia. Additional internal elements were that Alex had not received any education in disability or violence areas but had received some training at work, on issues that pertained to mental health but not partner violence. A final internal element was Alex's desire to advocate for disabled women (ethical decision).

> I'm thinking about women with depression and anxiety, addictions, and other challenges [and I advocated for] housing. It was a hotel, it might be the tallest building in town maybe 5 stories, so there were some challenges for housing.

Figure 10. Alex's contextual diagram. This figure shows influential elements in this social

worker's practice context when she worked with disabled women who had experienced MPV.
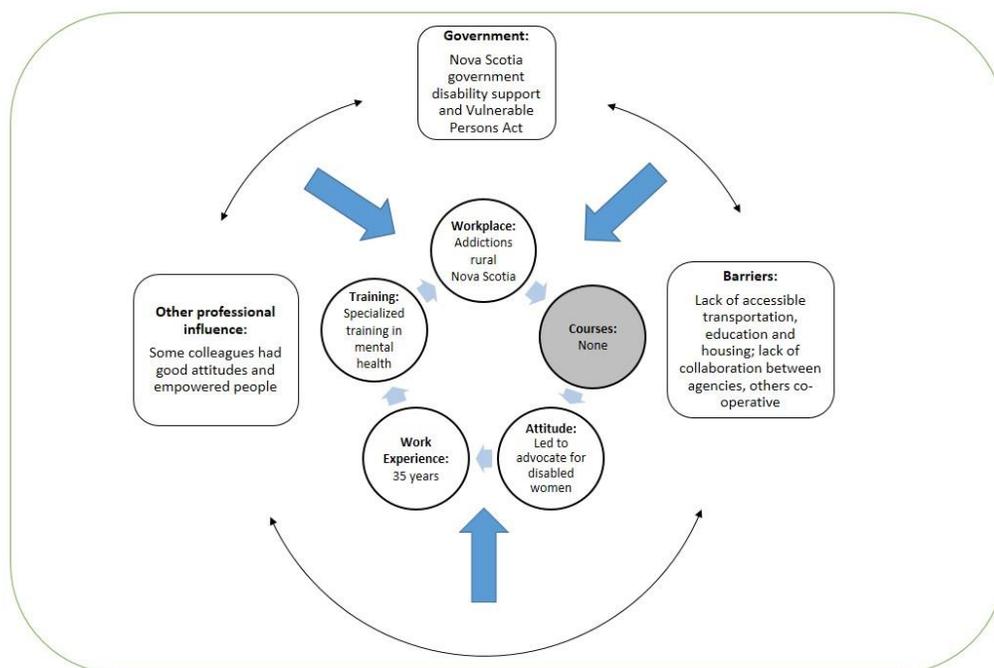
External element. An external element or what could be considered part of the political

context was the Nova Scotia Government's Disability Support Program, based on the Nova

Scotia Assistance Act that narrowly defined the disability criteria, as being unemployable and

that was used to determine who could receive social services and other benefits. Alex also talked

about the Nova Scotia Vulnerable Persons Act that mandated Alex to report to police, any

suspicions of abuse of disabled women with "cognitive impairments" (participant's term). Other

external elements were barriers such as the lack of accessible buses and housing for disabled

women and how some agencies (not specified) worked in silos, while others were co-operative

when it came to providing services to disabled women. A final external element (or positive

culture) was the positive attitude of her colleagues in the addictions department in which she

worked. Alex said "The addictions unit is quite a special unit here where I work, so we look at empowering beyond barriers and being respectful".

Riley's Practice Context.

Internal elements. Riley had a Master of Social Work degree and as seen in Figure 11, contextual influences included internal elements, such as having worked as a social worker for 13 years, for a family and child services agency and in developmental services for a large city in Ontario. Additional internal elements were the completion of social work university courses with content on partner violence and disability, no training in partner violence issues and workplace disability training (e.g., making information on partner violence more accessible to disabled women with cognitive impairments by writing it in plain language or presenting material at a slower pace). A final internal element was Riley's desire to increase public awareness about disabled people and their value in society.

> Right now, disabled people are not [perceived] as valued members of society because a lot of people see them as being a drain on society because they are on [provincial] disabilities support program. However, if you actually talk to the person, I don't know how many would actually like to be on disabilities support, they would love to be able to work. I know some men and women who work, who have Down's syndrome and they are the best workers because they come on time and they do their job. They're very particular about that and whatever way you show them, that's how they continue to do the work.

Figure 11. Riley's contextual diagram. This figure shows influential elements in this social worker's practice context when she worked with disabled women who had experienced MPV.
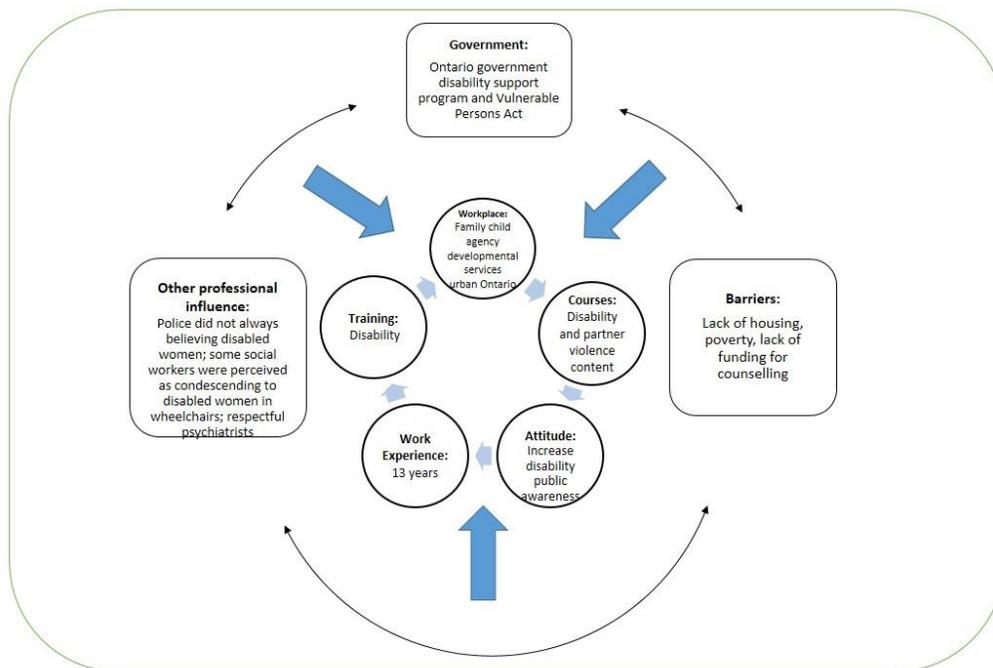
External elements. Other external elements or what could be considered to be part of the political context was the Ontario Disability Support Program that was based on the Ontario Disability Support Act that defined the disability criteria as being unemployable and was used to determine who could receive social services and other benefits, as well as the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act (2013) that Riley said was used to report abuse that was perpetrated on disabled women who had "cognitive impairments" (participant's term). Riley said that this Act provided support to social workers in Ontario because it specified when social workers should call police when vulnerable adults were abused or neglected. Riley talked about what could be viewed as a culture of non-compliance when she said that police had refused to lay charges before the law was enacted, but

now they could not refuse to investigate abuse cases. Riley said that the Ontario Government was

working to make better laws for vulnerable people but at the time of the interview, Ontario did

not have a Vulnerable Persons Act.

> The police may not have taken it seriously [before] whereas now …this legislation is for anybody who works with people with 'intellectual disabilities' (participant's term). At least we have to report, so I feel like at times, when nothing comes out of it but there's signs [of abuse], at least now there's a report or a couple of reports, [so the police] might say, "ok there's substance there".

Another external element or culture of prejudice was that Riley perceived her colleagues

as having biased attitudes towards disabled women who had experienced MPV. She said that

some social workers were very condescending to disabled women who used wheelchairs because

they would talk to them, as if they were either deaf or small children. However, Riley did say

that there were some very respectful psychiatrists who worked in local hospitals.

> It was primarily social workers in a clinical setting in the community [that were disrespectful]. Women that are in a wheelchair, or a walker, I found that people are quite condescending towards them. They almost treat them like they have a cognitive impairment, like they're a child. I find that a lot of women that I work with have pride, of course right, so they do want people to respect them and treat them in a certain way, but as soon as someone starts doing that, it's not leaving a positive feeling. I don't know if they're likely to come back and receive the service again. But there were very respectful psychiatrists that I worked with in hospitals, as well.

In summary, internal and external contextual elements shaped the practice contexts of

individual social workers who had worked with disabled women who had experienced MPV.

Similar contextual elements that were mentioned by social workers in this study included

barriers such as a lack of accessible shelters and transportation, influences from other

professionals, and the absence of collaboration between agencies and the limitations of

government policies and service eligibility criteria.

Different contextual elements that were outlined by social workers in this study included

the work setting, education, training, provincial government mandates and legislation. Although

it was not possible to account for all interactions between contextual elements, as mentioned, interactions that helped to shape social workers' experiences when they worked with disabled women, were education and/or training, years at the same workplace and social workers' attitudes, provincial government programs, legislation and mandates.

In this study, two social workers' attitudes indicated support of provincial government mandates and legislation, as these offered clear directives to social workers (e.g., calling police when abuse is suspected) while, five expressed feeling limited precisely, because these provincial policies were not broad enough (e.g., disability criteria too narrow). Ironically, three social workers in this study said that provincial governments' policies that prioritized services for women who had experienced MPV had not addressed the need for accessible housing in their provinces.

Three social workers in this study found that other professionals' biases against disabled women who had experienced MPV resulted in disabled women not being welcomed at women's shelters or being disrespected when trying to access medical services. In contrast, two social workers in this study praised healthcare professionals for having very respectful attitudes towards disabled women, for working with authorities to help disabled women leave their abusive relationships and even going above and beyond their usual workplace tasks to help disabled women who had experienced MPV.

While individual contextual elements provided some descriptions of social workers' experiences when they worked with disabled women who had experienced MPV, a cross-case analysis was used to explore patterns found in the data of participant's interviews. From these patterns, themes were identified and revealed participants' perspectives that were related to the interview questions.

Part Two – Themes

This section presents the themes that were identified from the participants' responses to the interview questions and literature that was used to triangulate and validate these findings.

The Lens of Disability.

Disabled people are frequently perceived as being different by mainstream society and as a result, this may affect how they are defined in comparison, to the rest of society (Canales, 2000). "Persons are categorized or labeled according to perceived differences from the societal norm. Once labeled as different from this prevailing norm, they are stigmatized. It is this stigmatization that constructs their identity as other" (Canales, 2000, p. 5). This labelling process contributes to non-disabled people's perception that disability is an anomaly, rather than an element of human diversity (Hansen & Philo, 2007). Thompson and Ezell (2005) argued that when disabled individuals are defined in terms of deficits, it justifies a formal limitation, to their opportunities and basic rights. Instead of trying to provide unique social services to disabled people, these same authors argued that a more inclusive society would accept and accommodate all differences however, Hansen & Philo claimed that this is not yet true of most modern societies.

In this study, participants were asked to define both disability and male partner violence. They were then asked about federal or provincial legislation, mandates, programs or policies that might have affected their work with disabled women and to discuss models or theories they had used in their practices with this same population of women. Participants then spoke about barriers that were encountered when working with disabled women who had experienced MPV. Social workers were then asked about their workplace settings, their advocacy work for disabled women and their professional perspectives on services that worked or did not work with disabled women who had experienced MPV.

Definitions of disability clustered around three themes: *Institutional power over the definition of disability*, *self-defining may be disabling*, and *a disabling environment* while, definitions of male partner violence against disabled women were centered on two themes: *violence is violence* and *the complexities of violence*.

Theme One: Institutional Power Over the Definition of Disability.

Brisenden (1986), a disabled activist argued in his formative work that healthcare professionals such as physicians and hospitals that employ them, have been validated by governments, as 'experts' on the subject of disability. Furthermore, as mentioned in chapter three, the medical model or the individual model of disability, as it is sometimes known, has continued to influence the classification of disabled individuals, by individual deficits (Shakespeare, 2006).

Four social workers in this study thought that disabled women were exposed to a medicalized process of labelling (diagnosing); in particular, they had their impairments recognized by healthcare professionals, prior to receiving social services. Others reflected on the consequences of not fitting the criteria. For example, Alex and Taylor said that disabled women had to get a physician to confirm their impairments and that others were denied treatment when they could not be easily labelled.

> There was an example of [having] to jump through hoops...to get certain people to sign off. Doctors or whoever, someone had to say you've got something in order to make, it real. In a medical setting, everything is medicalized and people are often described in a certain way [by individual limitations].

> It was the way that the institution perceived, handled and treated individuals there. That was a problem. You didn't honor the person's strengths and [you tended to] look at all the weaknesses. One thing that strikes me here is how they expected people to fit...in a certain box and if you didn't meet those criteria then you weren't treated.

These words appear to reflect the power and control of the medical model that is part of the workplace environment in healthcare. The medical model or individual model of disability is based on the notion that an individual has deficits that deviate from the norm and cannot be made whole by medical intervention (Shakespeare, 2006). Thus, the individual is considered disabled and deserving of services (Rothman, 2010). Rothman argued that proof of disability is still necessary to access social welfare services and the only way to get this evidence, is currently by using a medical diagnosis of disability.

Taylor, Riley and Mackenzie reported that disabled women were essentially branded as 'deficient', by 'medical experts', such as physicians. Not being labelled was also problematic, because as Alex suggested it meant that disabled women were not able to receive services. When this happened, social workers in this study, such as Alex and Riley admitted to bending the rules and going out of their way to help disabled women, who did not fit the disability criteria.

> [Provincial policies were] too exclusionary, [they were] not so much couched in disability, but there were a lot of policies that limited the way that you could help people. It was one big part of [our work, trying] to break the rules in order to help people.

> A lot of these policies were restrictive [and determined] who could get the help and who couldn't [because of] how they defined their disability. The medical field I felt… was strictly based on impairment, so focused on what a person could not do whereas, we tried to flip it around…we tried to focus on what a person could do.

On one hand, these statements demonstrate that social workers did not necessarily have complete freedom to determine who received social services because they were bound by disability criteria used to determine who could obtain provincial income support. Lightman, Vicks, Herd and Mitchell (2009) reported that governments typically require fixed categorizations to determine eligibility for disability benefits and that this could be an issue for individuals with episodic disabilities [2] because symptoms in episodic disabilities may come and go. On the other hand, the above comments indicate that some social workers had used their creativity and discovered ways

to navigate a restrictive system to accommodate service user's needs. As mentioned, the medical model's definition of disability is often too narrow, perhaps explaining why some social workers in this study opted for disabled women's own definition of disability.

Theme Two: Self-Defining May Be Disabling.

Three social workers in this study suggested that disabled women were responsible for defining their disabilities and their definitions were based on their self-perceptions and feedback from their social environments. Taylor suggested that negative self-perceptions were in fact disabling, rather than empowering and that disabled women who perceived themselves as incapable, were creating their own limitations. She went on to argue that society played a role in the definition by reflecting how disabled women saw themselves and vice versa.

> If you see yourself as weak and incompetent, as not very knowledgeable, or not intelligent…you could say this is a disability. So [if] a person is disabling themselves in terms of their perception of themselves…it can lead to controlling [what they do]. I'm sure that society has an impact on that as well but it's also how we see ourselves that's how we see society, it's a feedback loop, I don't think that it's just one thing.

It may be that disability is part of a feedback loop that includes the disabled woman and society; in fact, Shakespeare (2006) proposed that disability was a complex interaction between the built environment, society and the individual's impairment. He argued that the repression that disabled people experience is both inside and outside the person (Shakespeare, 2006). For instance, disabled people may feel incapable or worthless because they cannot manoeuver their wheelchair in an inaccessible environment or feel ugly because of people's prejudicial comments (Shakespeare, 2006). It seems that Shakespeare was saying that disabled people internalize what they experience in society and these experiences could become part of their self-definitions but that the built environment, also has an impact on how disabled persons see themselves.

In contrast to the previous definition, Riley from Ontario provided a vivid account of women who did not define themselves as being disabled. "[Disabled women] that I worked with didn't feel that they were disabled to some degree, the higher functioning cognitively disabled [women] wanted to be like everybody else and didn't see themselves as having any kind of disability; they would say I kind of learn differently, than other people". This statement echoes a text by Morris (1991) who noted that we have failed to see the potential benefits of viewing bodies that are normal but 'different'; rather, most people assume that different bodies require 'some kind of medical intervention'.

> Our bodies generally look and behave differently from most other people; even if we
> have an invisible physical disability there is usually something about the way our bodies
> behave which gives our difference away (Morris, 1991, p. 16).

Mainstream society has yet to accept people who are 'normal', but who do things differently. For this reason, it is reasonable to acknowledge that people want to obtain or maintain a positive self-concept and not be considered different from anyone else (Deal, 2003). A couple of participants elaborated further by identifying mainstream society as being responsible for creating disabling environments.

Theme Three: **Disability Defined by Disabling Environment.**

Two social workers in this study spoke of non-disabled people as being responsible for setting up a disabling environment. In particular, Mackenzie explained that disabled people would not be defined as disabled, if their environments accommodated their needs.

> Disability [is] defining people as not being able to manage within the world that we have
> set up and there's no recognition that we've set up the world that way, according to our
> needs. If the world was set up differently, by different people, then they wouldn't appear
> to be disabled, they would just appear to be navigating the world, because it's been set up
> to facilitate their life, their participation.

Recognizing that non-disabled people have organized the world according to their own needs is in line with the social model that explains how disabled people are limited by dominant perspectives, and by non-accessible environments (Quarmby, 2011; Thomas, 2004). This recognition shifts the responsibility for the concept of disability from disabled individuals to the disabling environment that was constructed by non-disabled people (Quarmby). Interestingly, social workers in this study who defined disability as an individual problem or who left it up to disabled women to define themselves, also conceptualized disabled women's experiences of male partner abuse, as being similar to non-disabled women's experiences of male partner abuse but did not mention that disabled women's experiences of male partner violence are often more complex.

Theme Four: Violence Is Violence.

The majority of social workers in this study spoke at length about disabled women's experiences of MPV and described it in terms of being physical, psychological, financial, sexual and emotional male partner abuses. They also said that their workplaces defined male partner violence in terms of physical and emotional violence only. Avery and Lee described male partner violence against disabled women as the following:

> [Male partners were] demeaning… it totally destroyed a disabled woman's sense of herself. The male was controlling in that respect and… it was physical but there was a lot of intimidation…demeaning kinds of interactions and just very destructive in that respect…. how this woman experienced herself in the world destroyed any positive experience of who she was.

> I got the opportunity to meet a woman who had vision issues and sat in a wheelchair. Her [husband] got involved with another person and there was no physical violence but there was a lot of emotional abuse going on, [to] the point where, I had to help this lady to leave the house…she was pushed and she had a terrible fall and I would say this was physical abuse because he just pushed her and she went down the stairs. I don't know if the intention was to hurt her or what the intention was.

The majority of social workers in this study did not describe the type of abuse that can be more specific to disabled women, such as mentioned in chapter three (manipulation of medications); however, a few participants did acknowledge that disabled women's experiences of MPV were more complex than those of non-disabled women.

Theme Five: Complexities of Violence.

Four different participants revealed that in their practices, disabled women were likely to experience complex male partner violence. For instance, Jesse, Riley, Kelly and Lee mentioned different types of control that a male partner could exert on a disabled woman, particularly, if he was also her carer.

> If the partner was in a caregiving role, he delayed things or did not do things right away.

> If someone needed to move from say, the wheelchair to the bed, he said 'well we'll do this more at my leisure, so not when you need it'.

> I mean if you depend on your partner to take you to the bathroom or wheel you from here to there, to get you to appointments you know, you're more dependent.

> I recall this [particular disabled woman]. She made a list of things that she wanted [her husband] to get from the superstore, but when he came to buy the groceries… he just ignored her and she was so devastated. She was crying one time and told me that I can't have what I love to eat because my husband won't get it and I was like 'this is abuse'.

Reports such as these emphasized the complexities and vulnerabilities of disabled women's experiences of MPV, in comparison to non-disabled women. One of the main reasons cited for these types of abuses is unequal power relations (Olsvik, 2006). As a carer, the male partner finds himself in a position of power over his disabled partner and may use her disability against her (Olsvik). Olsvik found that disabled women were humiliated or frightened into silence by their controlling male partners. Most participants in this study were aware of the power issues in disabled women's violent relationships and were careful to use established or evidence-based theories or models in their practices with disabled women who had experienced MPV.

Theme Six: Theories, Models or Approaches.

The majority of social workers in this study stated that they had used strengths-based and person-in-the-environment approaches (discussed in chapter four) when working with disabled women who had experienced MPV. Mackenzie talked about the importance of recognizing the impact of the environment in her practice with disabled women; this is similar to the social model (Oliver, 2012).

> If the world was set up different by different people then they wouldn't appear to be disabled they would just appear to be navigating the world because it's been set up to facilitate their life, their participation. I even find myself saying, ok so this person can't walk so it's our fault because we've designed a world full of stairs…what can be done.

Three participants stated that they used specific therapies, such as cognitive behavioral therapy (CBT, an evidence-based common type of talk therapy that is based on behavioral and cognitive theories, Cowdrey & Waller, 2015; Hersen & Gross, 2008; Mayo Clinic, 2016) when working with disabled women who had cognitive challenges and trauma based approaches defined as evidence-based therapies that focus on addressing traumatic events (The Trauma Informed Care Project, 2016; United States Government of Health and Human Services, 2016) with disabled women who had experienced MPV. Taylor who worked in private practice and in a hospital setting was an exception because she used psychoanalysis when working with disabled women who had experienced MPV.

She had trained in psychoanalysis and said that "…psychoanalysis helped… in going a lot deeper and to understand the ways that people behave and relationships that are repeated until [they] are worked through". Segal (2013) suggested that "to many, social work's adoption of Freud's ideas [including psychoanalysis, a type of psychological therapeutic technique] in the 1920s and 1930s marked a wrong turn, supposedly righted by replacing psychodynamic theories with systems-based approaches…" (p. 376). To others, psychoanalysis remains a viable option

because it moves away from quick fix solutions (e.g., short term therapy) that are typical of today's social work interventions, towards long-term types of individualized services (Segal, 2013).

Regardless of the type of approach used, it is often expected that social workers should rely upon evidence-based practices to ensure that services will have the most effective outcomes, as demonstrated by research (Social Work Policy Institute, 2010). There has been significant debate as to what constitutes *evidence-based practices* (EBP), (Simmons, 2012). In the beginning, EBP relied mostly on randomized experimental research designs and quantitative analysis to determine if a practice was valid (Simmons, 2012). Eventually, EBP did evolve to be defined as it is today, essentially "…the best research evidence with clinical expertise and patient values" (Sackett, Strauss, Richardson, Rosenberg, & Haynes, 2000, p. 1). This definition of EBP is client-centered and recognizes the clinician's ability to make reasonable decisions when it comes to working with service users (Simmons).

One client-centered approach, person-in-the-environment has been central to social work practice because it recognizes the reciprocity between service users and social environments; however, it is a complex process for social workers to make clinical decisions that are based on EBP, because there are no guidelines for social workers to follow (Simmons, 2012). In particular, social workers have to consider the service user's needs, social environments and use an approach that is evidenced based to solve the issue (Simmons).

Some approaches such as the person-in-the environment and the strengths perspective have been contested as these may not necessarily attend to the physical pain or built environment, to the disadvantage of vulnerable populations (Rogge & Cox, 2001). With this in mind, the person-in-the-environment perspective might seem applicable to the situation of

disabled women who have been abused by their male partners but in practice, social workers

applying it might not include the influence of the physical environment that contributes to

women's disability experiences (e.g., lack of accessibility and impairment). Evidence-based

therapies were used by most participants (e.g., cognitive behavioral therapy that is based on

cognitive and behavioral theories) who worked with disabled women who had experienced

MPV; however, the use of evidence-based therapies did not preclude participants from

expressing their uneasiness and desire to shield disabled women from harm.

Theme Seven: Vulnerability and Protectiveness.

Some disabled women's choices elicited feelings of uneasiness and a desire to protect, in

two participants. Riley expressed a profound sense of concern because she believed that disabled

women with "cognitive impairments" (participant's term) tended to be more vulnerable, more

isolated and at times rushed into relationships, when compared to non-disabled women. She

disclosed feelings of protectiveness towards disabled women who had "cognitive impairments".

Riley gave the impression of wanting to shield disabled women from the risk of male partner

abuse.

> When they had partners who were abusive, I found that their world got even smaller
> much quicker. It was my experience that the [disabled] women that I worked with were in
> very vulnerable situations. They were in very vulnerable positions to begin with,
> especially women who had cognitive impairment. A lot of them wanted to be in a
> relationship, they wanted to be treated like everyone else, they wanted to love and they
> wanted somebody to love them.

> So sometimes, I felt like that could put them at risk because they moved much too
> rapidly, like I met Joe yesterday and today we're moving in together. Sometimes, I would
> have to say well what's Joe's last name and they would say I don't know. I would say,
> well do you think that that might be something that you should find out before you move
> in? Sometimes, I felt that I was more protective of [disabled women who had cognitive
> challenges] that I worked with.

On one hand, these statements are similar to Pestka and Wendt's (2014) work who found that

disabled who had been abused by their male partners wanted to belong and be loved like anyone

else. On the other hand, this passage may be similar to some studies that explained how social

workers frequently perceive disabled women as dependent, childlike, not considered to be

involved in an intimate relationship, or in need of more intervention to guide them, when they

were in intimate relationships (Barranti & Yuen, 2008; Barrile, 2002; Collins & Valentine,

2003). Social workers who want to protect disabled women from harm may be torn between

treating disabled women as individuals who need protection and as individuals with a right to

make their own decisions (Dixon & Rob, 2016). "In practice, the balance between service user

autonomy and agency responsibility is complex" (Dixon & Rob, 2016, p. 5). Dixon and Rob

(2016) argued that social workers need to avail themselves of assessments tools for partner

violence to assess risks in situations that involved disabled women who have intellectual

impairments but also balance this determination with sensitivity and respect.

Conversely, despite having a protective tendency, Chris from Saskatchewan mentioned

the importance of respecting disabled women's rights and autonomy, even if their choices put

them at risk.

> I think it's really important that people learn about their rights because the tendency is to
> want to protect people as opposed to protecting their rights and it's a tough situation.
> They have a right to live where they want, even if we think it's not the best situation and
> that they are putting up with abuses. They have the right to have children and we have to
> support that right with the ability to make good decisions. That's my first tendency is to
> protect and then well, you do have a right to make your choice. There's what you need to
> know, but [realize that] your choice [could get] you into trouble. But we all take risks and
> make mistakes and learn from them.

Chris's opinion is similar to views of Beaulaurier and Taylor (2001) who explained that the most

important aspect of independence for people in the disability rights movement is the ability to

make decisions about one's life. These same authors emphasized the need for social workers to

be informed about the realities of a life with disabilities (Beaulaurier & Taylor). They specified

that a disability did not always make someone vulnerable, that it was not necessarily a tragedy and that misguided social workers might perceive it as such (Beaulaurier & Taylor). If well-meaning social workers perceive all disabled women as homogenous and in need of protection, these views may be considered paternalistic and may create more barriers than it tears down (Barrenti & Yuen, 2008). Attitudinal biases such as these may contribute to disabled women being defined as vulnerable and create a context that increases the likelihood of abuse (Barrenti & Yuen). In other words, if disabled women are conceived as powerless, they may be taken advantage of by male partners, who typically hold most of the power in the relationship (Barrenti & Yuen). In light of this possibility, social workers should balance risk assessment with the realization that disabled women have strengths and a right to autonomy (Beaulaurier & Taylor; Dixon & Rob, 2016).

Social workers in this study also spoke of barriers that were common findings in their work with disabled women who had experienced MPV. Their responses clustered around two themes: *structural barriers and attitudinal barriers.*

Theme Eight: Structural Barriers.

The majority of social workers in this study expressed frustration and embarrassment when they recalled the lack of accommodation experienced by disabled women they had worked with. They revealed that transportation, financial help, housing, employment, and women's shelters were often absent or not accessible to disabled women. Avery recalled how it was almost impossible to obtain financial assistance from the Nova Scotia Government for one disabled woman, who wanted to make her home accessible.

> Let's say someone had limited income and they were looking for a government program for help, to do renovations or something that needed to be done to upgrade their home or those kinds of things. Well they certainly had more policies around what a disability would be; you had to physically not be able to get into your house or [be] financially limited because of their situation [to get even minimal help].

Similarly, Alex said that "…in some cases ramps were still going to the back door instead of front doors and disabled women still had to consider where they were going ahead of time to make sure the area was accessible". This example demonstrates how accessibility remains limited and ramps are relegated to back entrances instead of being placed at main entrances, where they should be for easier access. Titchkosky (2011) explained that accessibility tells us a lot about who is allowed in a space and the meaning it has when some groups of people are left out. This same author added that the issue with accessibility is that it is taken for granted by people who don't have accessibility issues. Titchkosky encouraged everyone to fight for access because, at some point, those who have access may turn out to be the ones who don't have access. In other words, most people will likely experience disability, at some point in their lives.

Accessibility was a problem for a service user that Kelly was working with. Kelly admitted to feeling badly and visiting a disabled woman at her home for nearly fifteen years, rather than having her come to the agency office, because transportation was so inconvenient.

> [I] worked with her in a counselling and supportive capacity for 15 years because she had a great deal of posttraumatic stress because of what had been done to her [by her male partner]. She would be okay for a bit and then she'd have a bad dream or something, so I would go and see her [and] because she was disabled I usually went to her, to her home.

> [There was a] school bus and people with wheelchairs could go on it but there were issues with timing. She could go for an appointment but then that bus might not come back for two or three hours. It was only one bus trying to service so many people, so she could be done her appointment in half an hour and then she had to wait and wait and wait and what do you do if you have to go to the bathroom? So that kind of accessibility, I recall it being an issue and I felt badly for her and that's another reason I started to go to her home.

This passage illustrates one possible consequence of partner violence, such as posttraumatic stress, the compounding effects that structural barriers can have on disabled women's lives (e.g., perhaps not going to a much-needed service, such as counselling, because of a lack of convenient and accessible transportation) and the difference one social worker can make. Structural barriers are intimately linked to the question of access (Titchkosky, 2011). Access as Titchkosky argued is not just a matter of space but it may be viewed as the relationship between a person, his/her environment, his/her right to be in a particular place and his/her exclusion (Titchkosky). The disabled woman in Kelly's practice was provided with accessible transportation; however, the fact that the accessible bus did not come more often is an indication that little regard was paid to the inconvenience that this service created. The difference is that non-disabled people do not usually have to wait long for a bus, but this disabled woman did have a long wait because the accessible bus did not come frequently. There was no consideration as to whether the transportation service in question satisfied the needs of disabled women; after all, as Titchkosky argued that many times, access that is provided only meets the basic needs of disabled people, but their convenience is not considered by city planners. Perhaps, similar arguments are what drove Kelly to the conclusion that the transportation service was not good enough and why he felt compelled to do something about it, by going to the service user's home.

Could an alternative argument be that Kelly was creating dependence by going to this service user's home, instead of letting her come in for counselling? Kittay (2011) argued that helping disabled people does not take away their independence, by explaining that everyone, disabled or not has to depend on someone, at some point in their life. Kittay argued that disabled people have been viewed as dependent by mainstream society and some disability organizations have suggested that the way to reject this label and achieve the 'good life' is for disabled people

to become independent or at least be able to make independent choices. Kittay pointed out the flaw with this reasoning by saying that some disabled individuals are not able to make independent choices but this does not mean that they won't enjoy life. Instead, this same author contends that society should rethink how we view dependence and perhaps, replace it with an ethic of caring (Kittay). More precisely, Kittay suggested that morality should guide relationships between disabled people and their carers. For instance, morals of respect, cooperation and being attentive to the disabled person's needs are likely to be more beneficial than paternalistic responses (Kittay). Perhaps this is what Kelly was doing. He was being caring and attentive when visiting the disabled woman in her home and not taking away this service user's independence.

This section confirms that most social workers in this study were aware that barriers inconvenienced or at times prevented some disabled women abused by their male partners from obtaining the services that they needed. In situations where barriers were evident and there were alternative ways to accommodate disabled women, social workers attempted to meet their needs.

Theme Nine: Attitudinal Barriers.

Three participants were struck by other professionals' negative attitudes and their lack of understanding about issues related to disability and partner violence. For instance, Kelly referenced the stigma and the lack of disability knowledge in women's shelters. "Ignorance and stigma definitely [contribute to the refusal of disabled women in shelters], I don't think that the female staff at the shelter knew much about schizophrenia at all". Kelly said that women's shelters were usually quite good at accommodating disabled women however, there was one instance, he described where this was not the case.

Women's shelters, I found them to be quite welcoming of people, although I make that statement, but there was one woman who had schizophrenia and she went there…They thought that she wasn't stable…I disagreed and I called and tried to intervene on her behalf, but to no avail, and they asked her to leave.

A similar lack of empathy and understanding was conveyed by Riley, who recalled one rural physician's harsh comments about disabled people and how this made disabled and abused women uncomfortable to go to the doctor, because he was the only one available.

The doctor would say, 'I still don't understand why we are wasting our time with these people, why are we providing care for these people'? Unfortunately, [disabled and abused women are] already isolated because of their location and they only have access to this particular family doctor because it's a rural area. There's already not a lot of services, not a lot for disability and then you have a doctor who has an attitude like that, then how likely is it that you will go for services? I mean he closes the door and you…feel uncomfortable.

Riley also discussed how disabled women who had experienced partner violence wanted to be respected like everyone else.

People are quite condescending towards [disabled women who are in wheelchairs] and they almost treat them like they do have a cognitive impairment, like they're a child. I find that a lot of women that I work with have pride of course, so they do want people to respect them and be treated [like everyone else] and as soon as someone starts doing that, it's not leaving a positive feeling, so I don't know if they're likely to come back and receive the service again.

Unsurprisingly, this type of verbal denigration and attitude towards disabled women was not restricted to the healthcare field. Mackenzie was astonished at the negative attitudes that some social workers had towards disabled women who had been abused by their male partners. She confronted her colleagues about their preconceived notions; however, they justified their biases by stating that their perceptions were based on their many years of experience in the field.

I remember throughout my years of education, constantly [hearing] about how workers can further oppress clients and I thought that they were going overboard with that point, until I got in the field and realized that it was far worse than I had been prepared for. I definitely see [poor attitudes] from some income support workers and I see it in some social workers with child and family agencies.

> Even the social workers [who work in the shelter], they can be so jaded and when you try to challenge them on the assumptions that they are making they even justify their thinking by saying things like, 'well you know you have to understand when you've been in this field for as long as we have, you just know how cases are going to go; you just know that this person is not going to follow through and yes it's an assumption but it's based on a lot of experience'. I'm thinking you're defending this, you're defending your position, you're making negative assumptions about people.

On one hand, Mackenzie's strength in addressing negative views of professionals who were supposed to help disabled women, demonstrates that there are social workers who are passionate and ready to confront social workers who are not upholding the Canadian Association of Social Workers' Code of Ethics (2005) that states "social workers should respect the inherent dignity and worth of a person and practice in a competent and professional manner" (p.4). On the other hand, this example also illustrates that not all social workers are familiar or adhere to this same code of ethics.

This example makes it plausible to believe that some disabled women who had experienced MPV may not have received the best support they could have because of social workers who might have been less willing to work with them. Negative views of other professionals were also described by Riley who spoke of police officers that were skeptical of disabled women's claims of male partner violence and at times were even unwilling to pursue cases of abuse.

> [The police] said 'well because you can't tell us exactly when this happened and what time and who was present [we are not sure what we can do with this]' and I found that this is a huge barrier.

This statement is similar to Douglas and Harpur's (2016) study that found disabled women who were experiencing MPV were frequently frustrated and patronized by authority figures when they called for help.

In contrast, when police employed a staff liaison who was trained to work with disabled women who had cognitive impairments, the situation was improved. Riley said that "[when] we had a police liaison that we worked with, she was really good about educating other officers about disabilities… and dealing with different issues, it was a community collaboration" [therefore, cases were more likely, to make it to court].

Other aspects that almost certainly influenced social workers' work with disabled women who were abused by their male partners related to the settings they were in. Brown (2010) emphasized the value of contexts when exploring the complexities of people's experiences. For instance, social workers might have practiced differently depending on the work setting they were in. Two contextual themes that were related to the contexts included *locations* of *practice* and *settings*.

Theme Ten: Locations of Practice.

Participants were asked if they believed that their rural or urban contexts made a difference in their practices with disabled women who had been abused by their male partners. Rural social workers may have had fewer resources (e.g., women's shelters) to rely on compared to urban workers and have been considered generalists who have to use a variety of practice approaches to address more than one issue (Collier, 2006). For instance, it may be that when there are fewer social workers in rural areas therefore, they may be expected to provide several types of services to one family. Collier reported that in one family, a rural social worker had to inquire about children who were not attending school, provide counselling to their mother who had been abused by her partner, and provide counselling to the father for his partner abuse, addiction issues, and unemployment.

In this study, only two social workers in rural locations believed there was a difference between rural and urban practices. They cited the under-representation of services for disabled women who had experienced MPV in rural areas, how social workers often had to travel long distances and how rural social workers had to be more vigilant in case management of disabled women compared to urban social workers. Riley spoke of a rural area, where disabled women who had been abused by their partners were limited in the choice of healthcare professionals and had to see a physician who was clearly biased against them.

> [Disabled women were living a rural] location [and] they only had access to this particular family doctor…and there's was already not a lot of services for disability. Then if you have a doctor who has an attitude that [is against disabled people], then how likely is it that you will go for services? If a person had to face barriers with a disability and especially in a largely rural place like [this], then it became even more important that someone was managing the case, the case planning, to ensure that all the pieces…fit together.

Mackenzie talked about disabled women in rural areas and how they did not always know about the services that were available:

> A lot of disabled women didn't know that no matter where [they] were in the province that we could get them here, we could provide transportation. Some may have felt that because they couldn't leave their home without assistance and they couldn't drive here, that they couldn't get here but that's not true. We could get them here, unfortunately they didn't know this and until they contacted us we didn't know that they wanted to [leave their violent relationships] so it's a tricky thing.

Emerson said that when "…[I] had to go to court or something like that, I had to drive three to four hours" …. however, she specified that rural areas did not automatically mean more barriers for disabled women. Emerson who was working in a rural practice lauded their rural transportation system as being a good example of an accessible rural service, even if it was not perfect.

I mean there's always room for improvement, but like I said earlier, we do have a really good system here and it's been used as a model in the province and in the country. We are very lucky as far as transportation goes but I guess there's always room for improvement; [the accessible transportation] can only go so far and cannot transport [disabled women] to the big city, which is three hours away from where we are, so that might be improved.

Emerson's comments suggest that it might be possible to provide disabled women with appropriate services, even in rural areas. In fact, Collier (2006) implied that rural social workers have the necessary skills to challenge any social welfare services deficit that arises in rural areas. Collier argued that service users did not have to be deprived of services, just because they live in rural areas and that social workers ought to address any shortcomings by advocating for better services and by supporting communities, until their needs are met. Locations of residence were not the only contexts that shaped social workers' work with disabled women because specific *settings* in which they were employed were equally important.

Theme Eleven: Settings.

Social work is affected by the organisational context. Social workers are employees in public and private organisations, which have policies, guidelines, visions and missions, priorities, objectives and mandates to which a social worker is supposed to conform to.
Instead of making decisions that will solve clients' problems, social workers are often made to adhere to the rules, values and guidelines of their agencies that are not always in line with service users' needs. Similarly, as much as social workers are supposed to advocate for client self-determination in problem solving (through empowering clients to make decisions), they may not encourage clients to act in the manner they wish because they are accountable to the employer and legislative framework that authorises social work intervention (Chisala, 2006).

Workplace contexts often influenced how social workers in this study delivered services to disabled women who had experienced MPV. Workplace contexts included the physical setting

as well as federal or provincial programs or legislation such as the Canadian Disability Pension

Plan, the Provincial Vulnerable Person's Act and the Provincial Income Support Act or Program

(Canada Benefits, 2016) that social workers had to abide by when they worked with disabled

women who have experienced MPV. The Canadian Association of Social Workers (2005) stated

that social workers should abide by workplace expectations when they are in line with the

Association's Code of Ethics and work to change the policies when they are not. It is

understandable that this may not always be easy or possible because social workers may not be

equipped to challenge the authority that creates or enforces workplace policies or they may fear

losing their employment (Graham & Shier, 2014). For instance, Lee from Manitoba felt that the

workplace determined what professionals were likely to focus on when they worked with

disabled individuals. In Lee's example, a hospital setting reflected a medical context where the

focus was on the physical body and treatment and social workers who worked in hospitals were

embedded in the facility's workplace context and job expectations.

> If you worked in a hospital and you were working with physically disabled [individuals]
> it was a much different focus; it was more medicalized. I guess it was more focused on
> the physical and the medical.

 Kelly emphasized that he was discouraged by the Nova Scotia Health Authority to go visit

disabled individuals when they were in-patients; however, he said that social workers tended to

ignore this policy (not specified) and go anyway.

> We were strongly discouraged to see disabled individuals who were in-patients but we
> made exceptions to that and I know the reason why that policy was there. It was to
> prevent [social workers] from being overwhelmed with hospital requests.

This passage demonstrates that some social workers were committed to meeting service users'

needs, despite directives from their employers, to limit their services. This could be an indication

that some social workers had found creative ways to get around workplace policies that limited

services to service users. In contrast, two social workers talked about having to abide by specific

legislation when working with disabled women who had cognitive impairments; Riley said:

> There is legislation that came out a couple of years ago and it's now part of our practice
> to take abuse and violence very seriously. We have to report it like we do for children in
> society. Now if we have any sort of suspicion or anything then we call the police. The
> police have to investigate, that's specifically for people with intellectual disabilities and
> with that we have to do our part…It is our mandate and how we provide service.

Emerson echoed with a similar comment by saying that "if something [negative] happened we

could always say, that it was not part our mandate" because the legislation was specific to

physical abuse and applied to vulnerable disabled women, more specifically disabled women

who had cognitive impairments. These comments seem to reflect a belief that legislation was in

place to protect the service user, the social worker and the provincial government. It could be

said that these two participants had found benefits in the provincial legislation that protected

vulnerable individuals because it outlined specifically, when to intervene in cases of abuse and

when not to. Participants were then asked about their perspectives on resources that were useful

and any gaps in services for disabled women who had experienced MPV. Two prominent themes

were identified: *Failing to help disabled women and what is valuable* and *useful.*

Theme Twelve: Failing to Help Disabled Women.

Three social workers in this study cited communication difficulties between various

provincial government agencies and their negative impact on disabled women's services. For

example, Jesse, Alex and Mackenzie stated that provincial government agencies were operating

in individual silos instead of working together and that service could be improved by having

better communication between various agencies.

> I mean it's even difficult to get two branches of the same department of the [Provincial]
> Government to talk to each other, like Income Support and Child Protection. [These]
> used to be housed under one unit… here and now it becomes a mission to even get them
> across the table from each other.

We had a woman whose kids [were] in involuntary care and she'd been abused. Income support didn't want to pay for her to have a larger place until she got her kids back [but] child protection wouldn't give her kids back until she got a larger place, so we had to step in.

It seems to be in fairly individual silos, I think there's always this concern about confidentiality and consent. Yes, it is silos. I've had different people come and at some point they say, I see so and so at the women's centre or I do that. [You] don't always know that there are other organizations that are doing really good work and whether or not we're connecting or have time to do a follow-up. I find that difficult. Machura (2016) suggested that:

Attention needs to be paid to the system of inter-agency co-operation. It might be likened to a chain in which the weakest link decides durability. Beyond responsibility for their own organisation, social work management has to work with the partner agencies, if necessary alerting them to shortcomings (p.216).

One solution that was highlighted by Mackenzie was a push by the Prince Edward Island

Government to eliminate the duplication of services, by having a more open system, where

communication between services would be easier.

There's a huge effort around collaboration and partnering and eliminating duplication of services; there is a movement out there from the Health Authority and the [Provincial] Government... they are trying, but I find that in my private practice, I am in a bit of a silos here.

Mackenzie also pointed out the absurdity of having a priority housing list for disabled

women who were abused by their male partners when there was very little accessible housing

available. She said that "unfortunately if you're on top of a list that doesn't move, it doesn't

really matter does it? There's no movement, which is often the case for housing". The

implication of this argument was that the Provincial Government appeared to be making an effort

to prioritize services for abused women but in reality, disabled women remained without

accessible housing. This situation is an example of what happens when governments lack the

political will to turn their words, into meaningful actions.

The majority of participants also noted the lack of work opportunities for disabled

women. This finding was supported by research such as that of Dag and Kullberg (2010) who

found that disabled women had fewer job opportunities compared to non-disabled women and

disabled men. These same authors also reported that disabled men were typically offered work

that was less supervised than disabled women (Dag & Kullberg); therefore, it was not

unexpected that social workers in this study expressed their frustration in trying to find

employment for disabled women who wanted to work. Mackenzie said that jobs for disabled

women were limited and not meaningful.

> Really the only job opened to [disabled women] where you can sit down and you're not
> standing and you're not on your feet is something like a call centre, but it's not
> meaningful work or [a place where you] build esteem and that's unfortunate.

The immediate implication in situations like these are that disabled women are

 not provided with appropriate accommodations, that could possibly translate into better

employment opportunities. Yet, the broader implications are that disabled women who are

meaningfully employed are likely to have better self-esteem and become full participating

members of society (Titchkosky, 2011). In the long run, as employed citizens, disabled women

would be contributing even more to the economy, than they are now and perhaps rely less on

their partners for financial support.

Theme Thirteen: What Is Valuable and Useful.

Barranti and Yuen (2008, p. 124) found that programmatic accessibility ensures that
women with disabilities are able to receive disability-sensitive services. Accessibility
requires outreach and prevention programming; accommodations with services and
materials (medication replacement, assistive devices, and personal attendants), staff
trained in disability awareness, and established program policies.

Social workers in this study were aware of services that they considered valuable when

working with disabled women who had experienced MPV. Two participants mentioned disability

organizations and mental health services in their respective provinces as being quite helpful.

Another example was from Emerson who stated that the city's newly acquired 'accessabus

transportation service' (participant's term for accessible transportation) meant that disabled

women were less isolated, and from Mackenzie who described a helpful and unique loan

program that was available to disabled women who had been abused.

> The credit union developed a special loans program that allowed [disabled women who had been abused] to borrow enough money to make a down payment. The payment that they had to pay back was very small… so it enabled them to get a loan [and] they could buy… a second hand mini home. They could have their own place and that is one thing that happened in this community years ago and women were able to move out of these dumps and move into their own place. [The] women had their own home and it changed everything.

These examples demonstrate that participants were knowledgeable about services for disabled

women who had been abused by their male partners. This finding is hopeful because it suggests

that informed social workers are more likely to refer disabled women to the available services or

pass the knowledge on to them.

Two social workers in this study talked about the value of ongoing education and

specialized training for social workers who work with disabled women who had experienced

MPV. For example, Kelly talked about a training program, referred to as the Hyde training and

the Nova Scotia Government's initiatives to reduce mental health stigma and increase public

awareness. "The Hyde training...was to help people understand the impact of the stigma that we

carry towards people with mental illness and how to relate in a more humane and compassionate

way towards people with mental illness". Another example was offered by Chris who spoke

about raising disability awareness, because too few people really understand how to be respectful

of disabled individuals.

> We have a group here and there's three young women in wheelchairs with fairly significant health challenges. They're participating in kinesiology, physical education and education courses; even though these young women are nonverbal, with their supporters they are teaching the course. [They are teaching how] to respect disabled people's rights and how they want to be treated and [showing] how they communicate. There's some really good stuff going on and our regional manager is also teaching a disabilities class right now.

In this example, it is feasible that teaching moments between disabled instructors and non-disabled individuals could have potentially reshaped preconceived notions of disability, into a greater understanding of human diversity and of doing things differently. Having young disabled women teach non-disabled individuals how to interact respectfully with disabled people, likely increased awareness and the understanding of disabilities. The majority of social workers in this study explained that sometimes they also had to raise awareness, by being an *advocate* for disabled women who had been abused by their male partners.

Theme Fourteen: Advocating for disabled women who had experienced male partner violence.

Even though advocating is a core task in social work; not all social workers are comfortable advocating however, as a professional body, social work is committed to doing what it can to reduce society's injustices (McNutt, 2011).

The majority of social workers in this study stated that advocating for disabled women who had experienced MPV occurred often. They wrote letters to politicians on behalf of disabled women when their benefits were reduced or when their benefits were denied because they did not fit the federal or provincial government's disability criteria; they called women's shelters when disabled women were refused a room, they worked with landlords to secure accessible housing, they obtained funding for disabled women who required modifications to their homes

and they convened meetings between various government departments on behalf of disabled

women who had experienced MPV. Lee said that writing letters was just something that she did.

> If I had to communicate to a Minister I would call, I didn't care. I would say to myself,
> 'okay [it needs to be done]' and I made the phone call. Two or three days later people
> would be calling back, or even by email, I would write MPs, I would write every night.
> We had disabled women who had been denied CPP disability and I wrote to their MP and
> I would send the right information, for physiotherapy or whatever.

Only two out of ten social workers in this study said that they were unable to take on advocacy

work directly for disabled women who had experienced MPV, because they were in a private

practice and did not have enough time. Even these particular social workers contributed in

different ways; one participant was on a local women's shelter board and the other provided free

counselling to disabled women who could not afford it. Social workers in this study demonstrate

that most participants had a strong commitment to advocate for disabled women who had been

abused by their male partners. An additional theme that was identified by social workers in this

study was *a lack of accessible information* for the prevention of male partner violence.

Theme Fifteen: Lack of Accessible Information.

As mentioned in chapter three, a lack of accessible information such as materials that are

presented in braille, large print or simple language can affect disabled women's access to life-

saving knowledge, their capacity for self-protection, and can produce a sense of vulnerability and

isolation (Johnston-McCabe et al., 2011). Two social workers in this study explained that some

disabled women in rural locations did not have access to information and did not know where to

go for help. Participants said that in some cases, accessible transportation was available but

disabled women were not aware of it. Emerson explained that "disabled women didn't know

where to go or who to ask for help… even though it was a bad situation". Similarly, Mackenzie

stated that it was not an easy situation because some disabled women did not know that there

were services in place to help them.

> Many disabled women… don't have the means to leave. A lot of women don't know that
> no matter where you are in the province, that we will get you here [at the shelter], we will
> provide transportation. Someone may feel that because they can't leave their home
> without assistance that they can't drive here, so they can't get here [but] that's not true
> [because] we would get them here. Unfortunately, they don't know this and until they
> contact us we don't know that they want to get out, so it's tricky.

The words of the participants send a clear message that more accessible knowledge and

education is needed to make disabled women aware of the services and options that are available

to them. Otherwise, disabled women might remain in abusive relationships, rather than access

resources and receive help and/or leave. Similarly, Barranti and Yuen (2008) reported that

information about shelters and services was lacking and not easily accessible by disabled women

who had experienced MPV. They found that male partner violence websites were not up to date,

educational materials were not offered in alternative formats such as braille and typical points of

contact that would likely screen for male partner violence such as police, emergency rooms and

courts were not prepared and did not recognize disabled women's experiences of male partner

abuse (Barranti & Yuen, 2008). As a result, Barranti and Yuen suggested that disabled women's

experiences of MPV remained invisible and their needs were often unmet.

In summary, a number of elements characterized each participant's practice context and

their work with disabled women who had been abused by male partner. These included various

government legislation, policies, programs, directives, professionals' influence, barriers as well

as the number of years working as a social worker, specialized education or training in partner

violence or disability, social workers' attitude and their work location. Describing individual

social workers' practice contexts allowed similarities and differences to be compared and

provided the setting for the themes. Cross-case data from social workers who worked with

disabled women abused by their male partners were used to explore patterns and formulate themes ultimately, providing answers to the interview questions that were posed to the participants. In the next chapter, a summary discussion, limitations, implications and conclusion are presented.

Chapter Six: Summary Discussion, Limitations, Implications and Conclusion

Summary Discussion

This summary will show how some social workers in this study were engaged in a fight for disabled women's rights to receive social services. It will demonstrate that social workers had to contend with provincial policies and legislation that were often, too narrow to meet disabled women's needs. In some cases, social workers were left without the necessary skills and knowledge to challenge barriers that were preventing disabled women's access to these services. In other instances, social workers learned to be creative and found ways to circumvent government policies that prevented some disabled women from receiving social welfare benefits. Although it was important to understand where social workers were situated in their practices with disabled women (e.g., as allies and/or gatekeepers), this current inquiry also sought to reveal contextual elements that shaped social workers' experiences when they worked with disabled women who had been abused by their male partners.

The aim of this research was to inquire about social workers' experiences, perspectives and practice contexts when they worked with disabled women who had experienced MPV. More specifically, social workers were asked to define disability and male partner violence against disabled women, describe their work settings, education, training, advocacy work and years of work experience. Participants were asked about the theories or models they had used in their practices with disabled women who had experienced MPV, resources that were valuable and to identify any barriers that prevented disabled women from having their needs met. Social workers' responses to these questions provided an in-depth examination of social workers' understanding of disabled women and MPV while, adding new knowledge to the existing social

work and disability literatures, about aspects that could complicate or facilitate social workers'
experiences when they worked with disabled women.

**Research Questions One and Two - Social Workers' Practice Contexts and Defining of
Disability**

As discussed in chapter five, social workers in this study came from rural or urban areas
of Ontario, Manitoba, Saskatchewan, Nova Scotia and Prince Edward Island. They were
employed in a range of positions as case workers and clinicians who provided individual, couple,
family or addictions and crisis counselling, and who referred service users to other community
resources, such as income support or housing. Participants in this study practiced in hospitals,
mental health or addiction clinics, women's shelters, palliative care, developmental services,
while others were working for child and family agencies, community services or were in private
practices. Social workers in this study could be described as disabled women's allies because
they advocated for their right to receive social services when they were denied benefits and even
found creative ways to go around government policies to overcome what they perceived as
injustices. Other social workers could be viewed as gatekeepers because they accepted provincial
government legislation that did not go far enough to meet disabled women's needs.

Individual contextual diagrams show elements that shaped social workers' experiences
when they worked with disabled women who had experienced MPV and provided the context for
identified themes. These contextual elements include social workers' attitudes, colleagues'
influence, social workers' education, training, work experience, work setting and barriers;
however, the principal element, common to all of the study participants' practices were
provincial government policies or agency policies.

Provincial government regulations for healthcare and social services were front and centre when it came to influencing social workers' practices with disabled women who had experienced MPV. Findings showed that social workers who practiced in a healthcare setting, in developmental services and for child and family agencies used the medical definition of disability to determine disabled women's eligibility for benefits, such as social services or counselling. On one hand, it may have been difficult for social workers in a hospital or a child and family agency setting to avoid the medicalized view of disability (Oliver et al., 2012) when most individuals around them were practising according to the medical or rehabilitation models and because it was part of the criteria that was used to determine eligibility for social services. On the other hand, despite working in a healthcare setting, it became evident that some social workers were not focused on the medicalized view of disability that it is as an individual deficit or a tragedy (Oliver, et al.), because their work centered on the removal of barriers that prevented disabled women from obtaining resources they needed.

Some participants said the issue with this limited definition was that disabled women were likely to be denied benefits, when their disability was not considered sufficient enough to be granted benefits, by a medical panel of professionals. This insufficiency led some participants to advocate for disabled women, by contacting Members of their respective Provincial Parliaments, to show that disabled women were entitled to receive social services.

According to the Manitoba Income Assistance for people with disabilities program (similar policies or programs existed in other provinces in this study) disabled women had to be labelled as being unemployable (financial resources were not enough to meet basic needs) for a short (at least 90 days) or long period (indefinite) by a panel of medical professionals, in order to be considered disabled (Manitoba Disability Issues Office, 2001). Fitting the disability criteria as

outlined by a medical professional meant that service users could receive social services benefits and not fitting the disability criteria meant that they would be excluded from receiving social benefits (Manitoba Disability Issues Office, 2001, 2016). The Manitoba Disability Issues Office (2001) acknowledged that disability needs to be redefined, that employment resources need to be available to disabled individuals and services need to be available promptly, when someone becomes disabled. This is an indication that the Manitoba Government is aware that the criteria to determine disability are not perfect and that changes must be forthcoming.

Participants also pointed out that more specific provincial policies were often at play in defining service users' access to resources. For example, one participant said that in Ontario's developmental services, disabled women had to have at least one disability that was related to cognitive impairments, defined as impaired 'intellectual functioning' (Lightman et al., 2009) in order to access social services.

Although social workers in this study who worked in private practices, women's shelters, mental health clinics or addictions services said they were not mandated by the government to use the *medicalized view of disability*, they reported that provincial government statutes, such as provincial acts that protect vulnerable individuals still played a role, in informing their practices. Social workers who practiced in these areas emphasized their obligation to report any suspicions of abuse, of disabled women who had cognitive impairments, to police authorities.

Alternative definitions of disability were also offered by social workers in this current study. Participants who were practicing in women's shelters tended to define disability as being a problem with the environment or to rely on service users' definitions of disability, when they were in private practices. Defining disability in terms of a disabling environment is similar to the social model of disability that considers disability to be a problem with the environment

(Shakespeare, 2006; Oliver et al., 2012). As mentioned in chapter three, Titchkosky (2011) argued that the social model of disability makes a distinction between a person's impairment and the disabling environment. This distinction is paramount because it draws attention away from the medicalization of disability and situates it, as a problem in the environment (Titchkosky). Acknowledging that the environment is disabling to women who have experienced MPV could lead to improved policies and the removal of barriers (e.g. disability criteria that is not broad enough, lack of accessible transportation, housing and women's shelters) that prevent disabled women from accessing services.

These findings are such that even though government and agencies policies were the main influences on social workers' practices with disabled women, work settings and social workers' attitudes also played a crucial role in defining disability. The evidence in this study is similar to Evans (2012) who argued that social workers' practices were not just about following formal rules and policies. In this regard, he suggested that social work practice included an element of professional freedom (Evans). This means that most social workers have some level of discretion in the application of systemic rules (Evans). What became increasingly clear, in this current study is that social workers' attitudes and interpretation of government and agency rules resulted in what Evans described as practice inconsistencies. Social workers in this current study often found themselves in the middle; trying to respect disabled women's needs, while remaining accountable to a system that demanded efficiency and accountability, even if it meant limiting or denying services (Evans). Yet, it is possible to argue that social workers' willingness to advocate and their creativity in overcoming barriers, such as narrow government policies, were key factors in determining disabled women's access to certain social services. Accessing social services

were fundamental, because it meant that disabled women who were experiencing MPV and who were poor, now had the financial support to leave their abusive relationships.

Other social workers in this study had a different view, in that Provincial Vulnerable Persons Acts provided a sense of security to some social workers, because participants said the law was specific about when to call police authorities. Social workers who worked for child and family agencies said they called police when they had suspicions of neglect or physical abuses of disabled women who had cognitive impairments, defined as impaired intellectual functioning (Manitoba Government, Justice Department, 1996). Social workers in this study did not specify that the Manitoba Vulnerable Persons Act, that was used in their workplaces (similar to acts in other provinces except Ontario where one participant specified that the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2013 was used) also includes sexual, psychological, emotional and financial abuses that harm vulnerable individuals (Manitoba Government, Justice Department, 1996); although, the majority of participants were aware that abuse varied and could include more than physical and psychological violence.

Research Question Three - Barriers

Structural Barriers.

A deeper issue that became apparent in the findings of this study was the Provincial Government's role in the setting of social services policies and the allocation of services in all of the provinces. For instance, social workers in this study recognized a multitude of barriers that influenced their ability to meet the needs of disabled women, such as a lack of work, education, poverty, accessible transportation, housing and women's shelters. These barriers need to be addressed because evidence in this study demonstrates that provincial governments were not

always invested in the provision of services and resources that could have met disabled women's needs. The following section examines these issues in greater detail.

Disabled Women, Work and Education.

Social workers in this study admitted that disabled women had difficulty to find work. Findings suggest that there was no meaningful work available for disabled women, lending some support to Marroto and Pettinicchio's (2014) argument that disabled individuals have been given many reasons for having unequal access to the employment market. Employer explanations for not hiring disabled people were such that some disabled people required more time off than non-disabled people, they were less educated and less skilled (Marroto & Pettinicchio). Employers were frequently biased against disabled people because they were doubtful that certain work tasks could be accomplished by them (Marroto & Pettinicchio).

In their study, Collins and Valentine (2008) reported that disabled women were even more disadvantaged than disabled men because they were twice as likely to be unpaid in the workforce, and earned 30% less than disabled men. Disabled women were fives time more likely to leave school early compared to non-disabled women (Marroto & Pettinicchio, 2014).

Findings in this current study are also contrary to the aim of the 1995 Canadian Employment Equity Act that continues to promote the hiring of women, Indigenous peoples, visible minorities, and disabled people (Jongbloed, 2003; Employment and Social Development Canada, 2014). Social workers in this study stated that disabled women could not find work; therefore, they were unlikely to have benefited from priority hiring. Jongbloed argued, the reason for the failure of priority hiring was that the Federal Government had not established any enforcement procedures to support its own initiatives. The lack of federal government enforcement procedures to support priority hiring of disabled women today, resembles the

situation mentioned in chapter three, when the Federal Government lacked procedures, to enforce the priority hiring of veterans who returned from WWII (Neary & Granatstein, 1997).

Accessible Transportation.

Another structural barrier that was discussed by participants was the lack of accessible transportation. Participants reported that many disabled women in rural areas did not have accessible transportation and were unaware of services offered by local women's shelters. Several social workers in this study said there was a lack of accessible and affordable transportation, making it difficult for disabled women to access additional resources, such as counselling. In one case, there was accessible transportation but it was inconvenient because the service user had a long wait for the return trip. Participants mentioned that in cities, but not all rural areas, had some accessible buses however, these accessible buses were not available on all the routes or at all the times, as non-accessible buses. This is an indication that there was unequal access of certain services between disabled women who lived in rural and those who lived in urban areas. This is similar to Turbett's (2009) Scottish study that found rural transportation to be lacking; subsequently increasing isolation for disabled people in rural areas. Another transportation issue that was identified by participants in this study was the lack of accommodation for disabled women with dependent children. One social worker recounted the story of a disabled mother who had not been allowed to bring her child on the accessible bus because he was not disabled.

A common issue, especially in rural areas where there was no accessible public transportation, was that some disabled women who had experienced MPV, were unaware that women's shelters would have provided accessible transportation to them and as a result remained in their abusive relationships longer. This demonstrates a lack of awareness and that accessible

transportation has remained splintered across the provinces despite recent efforts by the federal Intercity Bus Code Policy to accommodate disabled individuals (McColl & Stephenson, 2008; Public Works and Government Services Canada, 2011). Participants described the lack of accessible and convenient transportation as a real problem that left many disabled women isolated and without access to life saving services.

Disabled Women, Poverty and Accessible Housing.

Social workers in this current study, also spoke about issues of poverty and how the lack of accessible housing was prevalent in the lives of disabled women in their practices. Hague et al., (2011a) suggested that disability is a gendered issue because disabled women are more likely to experience economic instability compared to both disabled men and non-disabled women. Participants said that in their practices, the majority of disabled women who had experienced MPV, were particularly disadvantaged because they did not have the financial means to leave their abusive relationships. Another issue raised by social workers in every province was the lack of accessible housing and the fact that it was more problematic in some rural areas. The lack of accessible housing meant that disabled women who had been abused by their male partners had few, if any housing choices, when it came to leaving abusive relationships.

This situation was a serious issue for disabled women, even though as mentioned in chapter three, most provinces like Nova Scotia had a partner violence plan that funded programs such as prevention, education, risk assessment, policing, prosecution, counseling, and support services (McInturff, 2013). Whether these services were accessible, included housing and met the needs of disabled women who had experienced MPV was not clear because disabled women were not specifically identified as service users, in these plans.

Social workers in this study reported that they were expected to follow agency and government directives by placing disabled women who had been abused on a priority list for housing and other services; however, they felt this was irrelevant due to the lack of accessible housing. An interesting finding in this current study is that most participants were knowledgeable about provincial polices and legislation however, the same could not be said about policy makers. Insufficient policies are an indication that policy makers were either unaware or unwilling to address the lack of resources. This example demonstrates how limited social services were, how government directives intersected with structural barriers and in some cases, even prevented social workers from being able to meet disabled women's needs.

Disabled Women and Women's Shelters.

A related concern was raised by social workers in this study when they spoke about women's shelters and inaccessibility. As mentioned in chapter three, provincial governments did have action plans concerning women and partner violence but they lacked specificity about disabled women's experiences of MPV. This meant that women's shelters might have been available but were not necessarily accessible and not all shelter staff had received specialized training or education to work with disabled women who had mental health issues. Lightfoot and Williams (2009) called for women's shelters to train staff because very few had received any disability awareness education and only 6% offered personal assistance to disabled women. Barranti and Yuen (2008) found that shelters claimed to be accessible but did not have space to store assistive devices or understand the role that a service dog played. As a result, shelter workers would suggest that disabled women stay with friends or relatives, potentially putting them at risk for violence (Barranti, Yuen). Despite their best intentions to meet the needs of disabled women in their practices, participants expressed frustration at not being able to find

solutions because of structural barriers that prevented them from helping disabled women find accessible shelters, housing or work.

Findings from this study point to a need to increase disability awareness and specialized training of shelter workers as this would encourage the dismantling of existing barriers that prevent disabled women from obtaining the help they need, to leave abusive relationships.

Social Barriers

Other Professionals' Attitudes.

Participants spoke of social barriers that had affected disabled women in their practices. One particular barrier was the attitude of professionals such as a rural physician who spoke openly about his bias and disdain of disabled people. Disabled women had to go to him for medical care because there was no other medical professional in that rural area. Satchidanand et al. (2012) argued that a physician's attitude towards disabled people may impact the care that is provided. When physicians have negative attitudes or a lack of knowledge about disabled people, the focus may be on the disability instead of on the person, as a whole or the overall care may be inferior compared to the care given to non-disabled people or treatment may be withheld altogether (Satchidanand et al.).

Another participant in this study gave an example of law enforcement's attitude towards disabled women who had been abused by their male partners. This social worker said that police did not want to bother to press charges, when disabled women were abused, because they assumed that the case would take years to be heard in court and by then, the disabled woman who had cognitive impairments would not remember the abuse. This same participant noticed a positive change in the attitude of the law enforcement personnel and police were more willing to lay charges when they employed a staff liaison, who had been trained specifically to interview

disabled women, with cognitive impairments. An additional complication mentioned was that social workers could not proceed with their own investigation until the police had completed theirs. Participants in this study, did not specify if this delay meant that disabled women remained in the abusive environments, while the investigations were underway. Bailey, Barr and Bunting (2001, p. 345) explained:

> The lack of opportunities among police officers to develop an awareness of the abilities and needs of people with intellectual disabilities (ID) has potential implications for the way in which officers perceive individuals who have ID. It is has also been suggested that a failure to appreciate the abilities of people with ID could have a negative impact on the manner in which offences against people with ID are investigated.

This current study's findings were similar to Bailey, Barr and Bunting who found that police officers who received specialized training or employed a trained liaison had were more positive attitudes towards disabled people and they were more willing to follow through with cases of abuse and disabled people.

Similarly, it appears that some participants perceived their social worker colleagues as biased for saying that most disabled women that used the women's shelter were not willing to leave their abusive relationships. It is difficult to determine if it was the number of years in social work practice, the rural work setting, a lack of specialized education and training, the type of work setting (e.g., women's shelter) or an entirely different element (e.g., personal characteristic) that fostered preconceived notions about disabled women. It is possible, as suggested by the participants, that their colleagues were cynical in their beliefs that disabled women would leave their abusive relationships or an alternative argument is they might have known that disabled women stayed in violent relationships longer than non-disabled women. Indeed, there is evidence

that disabled women who had experienced MPV took longer to leave than non-disabled women in abusive relationships because they feared being institutionalized, relied on their male partners to help them with daily living activities and financial support, worried their children would be taken away and were less likely to be believed when they reported the abuse to the police compared to non-disabled women (Barranti & Yuen, 2008).

Societal Attitudes Now and in the Past.

Most social workers in this study said they felt societal attitudes about disability and partner violence had changed because they recalled that over thirty years ago, both violence and disabilities were hidden, compared to today. They said years ago, police probably would not have charged a male for abusing his female partner. Some participants noted a difference in today's laws; in particular, how these laws are more specific to family violence (Canadian Department of Justice, 2015). Family violence laws may include court orders, breach of recognizance, harassment, mischief, stalking, making threats, indecent phone calls, trespassing, as well as any physical harm (Canadian Department of Justice).

The majority of participants also agreed that mainstream society's attitudes had changed when it came to male partner violence and said that over thirty years ago, people did not talk about relationship abuse and that women who experienced MPV were likely blamed for their circumstances. Ironically, more recent studies suggest that the public's perception of male partner violence has not changed a great deal, over the years and mainstream society still attributes a certain amount of blame to the abused woman, believing, that she has more control than she actually does, when it comes to stopping the violence in the relationship (Alfredsson, Ask & Von Borgstede, 2016; Taylor & Sorenson, 2005).

Participants also said that society was still judgmental when it came to disabled people. These views are similar to evidence reported in chapter three, that even though the majority of Canadians wanted to think of themselves as being inclusive, when it came to disabled people, many revealed their biases by specifying that they would be uncomfortable with some types of disability (Prince, 2009). Unsurprisingly, all participants in this study said that more education and public awareness was needed to increase the understanding of both disability and male partner violence.

Social Workers' Own Attitudes.

In the diagram representing social workers' individual practice contexts, as mentioned, one internal contextual element that could have intersected with government directives was a social worker's own attitude. Social workers who said they had perceived an injustice when disabled women were denied services said they felt a need to advocate and obtain social services for them. These actions reflect the principles and values of the social work profession to advocate for social justice (Canadian Association of Social Workers' Code of Ethics, 2005). For example, some social workers in this study were creative and said they wrote letters to Members of Provincial or Federal Parliaments when disabled women were denied benefits, provided counselling in disabled women's homes when accessible transportation was inconvenient and visited disabled women who were hospital in-patients, even though it was not required.

Conversely, social workers who were employed by developmental services or child and family agencies said they welcomed government legislation because it provided security for the service user and for the social worker. These social workers explained that prior to the provincial legislation (Vulnerable Persons Acts) that mandated social workers to report physical abuse and neglect of disabled women who had cognitive impairments, it had been difficult to get police to

respond and follow through with charging the perpetrator. Social workers accepted this government policy even though they admitted that it sometimes did not go far enough to address other types of violence (e.g., psychological violence).

Social workers in this study who expressed feelings of protectiveness towards disabled women who had been abused by their male partners might have been seen, as having a paternalistic attitude towards disabled women with cognitive impairments (Barranti & Yuen, 2008). A paternalistic attitude contributes to the social construction of disabled women as being vulnerable and powerless thereby, putting them at a greater risk for abuse.

Or, they could simply have been caring for disabled women; Kittay (2011) emphasized the need for professionals (e.g., social workers and physicians) and carers of disabled people to be caring, attentive and cooperative and that acting as such should not be considered paternalistic but compassionate and humane. In other words, caring and assisting disabled people to meet their needs is not taking away their independence, but ensuring it (Kittay). Disabled people may require assistance or assistive devices to be more independent (Kittay). Dixon and Robb (2016) added that social workers have to strike a balance between risk assessment and the autonomy of disabled women who have experienced MPV. These same authors also recommended that social workers work with authorities to safeguard disabled women from further violence (Dixon & Robb).

What was not mentioned in participant's interviews were ways of educating disabled women about male partner violence. Vecova Centre for Disability Services and Research (2011) found that disabled women were often perceived as being asexual; consequently, they tended to be denied prevention education pertaining to intimate partner abuse and sexuality. Partner violence prevention workshops and plain language resources may help disabled women

understand and recognize partner abuse (Dixon & Robb, 2016; Vecova Centre for Disability Services and Research). Disabled women are too often socialized to be compliant with their caregivers or healthcare professionals but they are not taught to speak up about abuses and about their right to live in a violence free environment (Barranti & Yuen, 2008). A related issue was that not all social workers in this study understood the complexities of disabled women's experiences of MPV.

Research Question Four - Social Workers' Practice Contexts and Defining Violence against Disabled Women

The majority of social workers in this study, with the exception of social workers in crisis clinics, in developmental services and in women's shelters, agreed with their employers' definition of disabled women's abuse of male partner violence as being physical and psychological; some added that at times it could also be emotional, financial or sexual. A few social workers in this study defined disabled women's abuse as being more than physical and psychological; they were able to give examples of complex abuses that included abusers' manipulations and control over disabled women. These descriptions were similar to Baladerian's (2009) depiction of disabled women's abuse by male partners; it is more complex than the types of abuses that are experienced by non-disabled women. It may include withholding of medicines or assistive devices or refusing to assist someone with personal care needs (Baladerian). Even when social workers in this study were asked whether there was a difference between the abuses that disabled women experienced in comparison to non-disabled women, few participants made the distinction; it is perhaps due to the limitations of social workers' education and training. Not recognizing the complexities of disabled women's experiences of MPV could have serious implications because it suggests that social workers could be failing disabled women (Barranti &

Yuen, 2008). Resources and lifesaving services such as outreach programs that provide

information to abused women may not reach disabled women, if social workers' understanding

of violence is limited (Barranti & Yuen).

Research Question Five –Theories, Models or Approaches

Social workers in this study were also asked if they relied on particular theories, models

or approaches when working with disabled women who had experienced MPV. The majority of

participants said they felt their employers expected them to use evidenced-based practices with

disabled women. Social workers in this study used person-in-the-environment, described

practices that could be compared to the social model, ecological, cognitive behavioral therapy,

trauma-based, and developmental approaches. The person-in-the-environment might have

seemed like an applicable approach, when working with disabled women however, Rogge &

Cox (2010) argued that social workers were likely to restrict their application of this perspective

to immediate social environments and not necessarily to the physical or natural environment.

The use of other approaches for example, psychoanalysis and Walker's power and

control wheel (1979) was rather an exception among social workers in this study when

counselling disabled women who had experienced MPV. The potential issue with approaches

such as psychoanalysis, cognitive behavioral therapy, trauma-based and Walker's power and

control wheel is that as mentioned in chapter four, these perspectives tend to focus on the

individual and do not necessarily consider disabled women's unique experiences of violence.

As mentioned in chapter four, alternative practice approaches that could be used with

disabled women who have experienced MPV included Dupré's (2012) social work cultural

disability approach, self-directed services (e.g., service users hire their own assistants) as well as

feminist, critical, and structural approaches (Pollack, 2004; Wood & Tully, 2013); these would

be more in line with disability organizations and better reflect disabled women's autonomy.

Social Workers' Education and Training

In addition, studies have established a link between social workers' education and

increased disability knowledge however, education did not always have an influence on social

workers' attitudes towards disabled people (Bean & Hedgpeth, 2014; Sullivan & Johns, 2002).

According to these same authors, social workers were more likely to benefit from disability

education and interact with disabled people in a more positive manner, when they had high self-

esteem themselves (Bean & Hedgpeth; Sullivan & Johns). Conversely, when social workers had

poor self-esteem, they were more apt to be judgemental against disabled individuals (Bean &

Hedgpeth). Bean and Hedgpeth (2014, p. 50) explained that "the self-esteem hypothesis posits

that individual self-esteem is associated with social discrimination, which is a person's attitude

toward people in minority groups based on different social contexts".

In 1993, the Canadian Association for Social Work Education (CASWE) conceived the

Person with Disabilities Caucus in order to oversee disability education policy, promote

disability courses, and make sure that disabled students would be recruited and retained into

university programs (Dunn et al., 2006). Dunn, Hanes, Hardie and Macdonald found that most

undergraduate social work programs in Canada included at least one course with disability

content but less than half of the graduate social work programs had a similar course.

The implications are that social work disability courses that are presented through a

feminist disability lens would address both gender and disability. As previously discussed, this

framework would take into consideration issues that concern disabled women tend such as being

less economically stable, less employed and therefore, more vulnerable than disabled men or

non-disabled women, when it comes to partner violence (Barranti & Yuen, 2008). This is important because understanding how gender and disability intersect could provide social workers with the knowledge required to recognize the more complex types of abuses that disabled women may experience compared to non-disabled women (Barranti & Yuen).

In this study, more recent education was reported to enhance participants' knowledge as they remembered and they applied their course learnings about disability and violence issues. Formal education was not the only path that social workers had to acquire disability knowledge because mental health sensitivity training for professionals in social work, healthcare and the court systems were mentioned by some participants, as a valuable educational resource. In one instance, two young disabled women taught a social work class. Social work students had been able to ask questions and interact with these young instructors and this experience had not only increased their knowledge but they said that it had also improved their confidence in working with disabled people.

Years of Work Experience

According to participants, the years spent in social work practice were also crucial in gaining knowledge about disabled service users. Social workers in this study who had been working for over thirty years but in various work settings were more knowledgeable about disabled women's complex experiences of violence than participants who had less work experience or who had remained in the same work setting (e.g., private practice, women's shelter); this could be an indication that more current knowledge on disability and male partner violence was due to the length of time spent in social work practice, experience and exposure to diverse practice issues, especially with disabled women.

Working Together or in Separate Silos

Some participants reported that certain government agencies refused to work together to meet the needs of disabled women. This issue was common across all provinces in this study and typical of Child and Family Services, as well as Income Support and Housing agencies. The majority of participants argued that agencies were more efficient when they belonged to the same department, compared to being in separate departments and buildings, as some agencies tended to be today. Another issue was the duplication of services. Participants said they would receive duplicate referrals for counselling from different agencies, for the same disabled women. Participants said Provincial Privacy Acts were often cited as the reason for not wanting to share information about service users. Yet, Provincial Privacy Acts, such as the Ontario Privacy Act (similar acts in other provinces) does allow agencies to share health information of service users through implied consent for the purposes of providing healthcare (Information and Privacy Commissioner of Ontario, 2004).

Another trend that was noted by a different participant was the use of multidisciplinary teams that included physicians, nurses, social workers, physiotherapists and other community workers who worked together to meet disabled women's needs. This approach was valuable because it saved time when everyone was in the same office because one service user could have complex problems that required specialized knowledge from various disciplines.

What Worked and Advocating on Behalf of Disabled Women

Other resources that were identified as being useful in social workers' practices with disabled women who had experienced male partner abuse included mental health services and disability organizations. These organizations were able to provide specialized knowledge and assistance to social workers in their practices with disabled women. One unique example of what

had helped disabled women who had experienced MPV was a credit union that provided low cost mortgages to disabled women to facilitate the purchase of their own homes. A participant said that disabled women were completely changed by the opportunity because they no longer had to live in a violent environment; a safe place to live had contributed to the transformation of disabled women thus, improving their self-confidence.

Social workers explained that sometimes they had to become active and raise awareness themselves, by being advocates for disabled women who had been abused by their male partners. Most social workers stated that advocating for disabled women was something they did often; as mentioned, they wrote letters to politicians on behalf of disabled women when their benefits were reduced or when their benefits were denied because they did not fit the Federal or Provincial governments' disability criteria for social services. They also called women's shelters when disabled women were refused a room, they worked with landlords to secure accessible housing, they obtained funding for disabled women who required modifications to their homes and they convened meetings between various government departments on behalf of disabled women who had experienced MPV. Having social workers successfully advocate for disabled women seemed to correct the injustice that had been experienced by disabled women. When social workers in this research were working in private practices and did not have time to advocate for disabled women, they volunteered on community boards or provided disabled women with free counselling when their claims for counselling were denied by the government.

Lack of Information

Social workers in this study called for an increase in public awareness about disabilities and male partner violence. Participants also explained that disabled women who had experienced MPV were lacking accessible information. For instance, disabled women who lived in rural areas

were often unaware that accessible transportation could be provided to bring them to the shelter. In addition, disabled women with cognitive impairments required specialized training and education to increase their understanding of male partner violence and be able to identify certain partner behaviors that were considered abuse. This finding was similar to the research by Barranti and Yuen (2008) who said that abuse was so common in disabled women's lives that they often believed that it was normal. For this reason, these same authors maintained that disabled women need to be given information that will inform them about partner abuse and teach them how they can protect themselves (Barranti & Yuen). For example, Deaf Hope provided disabled women who had experienced MPV with a 24-hour TTY hotline, counselling, support and advocacy (Barranti & Yuen).

Participants' impressions were such that the provincial government exerted the most influence on their practices with disabled women who had experienced MPV. Social workers in this study said that provincial governments defined the disability criteria used to determine who had access to social services, allocated the funding for social services and passed the laws that determined when social workers should intervene in cases of abuse and neglect of disabled women with cognitive impairments. However, social workers in this study did have an element of professional freedom (Evans, 2012). More specifically, they did have some level of discretion in the application of systemic rules (Evans). Social workers' attitudes and interpretation of these rules resulted in what Evans described as practice inconsistencies because social workers in this current study often found themselves in the middle; trying to respect service users, by meeting their needs and yet remain accountable to a system that demanded efficiency and accountability (Evans). As such, disabled women could receive different services depending on the agency

context disabled women sought services from, their social workers' understanding, willingness to advocate, creativity and application of systemic rules.

When asked to define disability, some social workers who worked in hospitals were more apt to use the individual or medicalized view of disability; even though the reason for the hospitalization may have had little to do with women's disability; for instance, disabled women may have been hospitalized for an injury or childbirth. It might have been challenging for social workers in this study to use an alternative definition of disability, in a setting like a hospital, where the use of the medical model to define disability was prominent and the focus might have been less on working with the whole person and more on 'fixing' the individual's body (Chisala, 2006).

Few social workers in this study indicated that they understood the complexities that disabled women could experience in violent relationships, because they did not appear to realize how disabled women's partner abuse could be unique when compared to non-disabled women's experiences of MPV. As mentioned, disabled women's abuses could include the manipulation of medication or mobility aids, neglect, destruction of mobility or communication devices, refusal to provide essential personal care, isolation, and threats of institutionalization (Powers et al., 2009). Social workers in this study also stated that barriers such as a lack of accessible housing, women's shelters and transportation had affected their practices with disabled women and had at times even prevented them from meeting the needs of disabled women.

Participants reported that negative attitudes among other professionals such as social workers, police or healthcare providers had resulted in disabled women being denied services or made uncomfortable to access social services or healthcare. Social workers in this study who had been practicing for over thirty years in the same work setting were less knowledgeable about

partner violence and disability compared to other social workers with similar years of experience, who had been employed in different work settings. It is possible that social workers had gained different knowledge by working in various work settings and that certain work settings were more focused on disability or violence against women. Specialized education and training could make a difference in social workers' understanding of the complexities of disability and male partner violence.

Most social workers in this study had used an evidenced-based approach when working with disabled women who had experienced MPV such as CBT or trauma-based or strength-based approaches (Mayo Clinic, 2016; United States Department of Health and Human Services, 2016). The majority of participants said they had advocated regularly for disabled women and stated that disability organizations and mental health services were two valuable resources in their practices with disabled women who had experienced MPV. Participants suggested that more public awareness and funding for disability was needed to improve upon the current social services and to meet the needs of disabled women who had experienced male partner abuse.

Limitations.

Anderson (2010) discussed several limitations of qualitative research.

[She suggested that] research quality is heavily dependent on the individual skills of the researcher and more easily influenced by the researcher's personal biases and idiosyncrasies. Rigor is more difficult to maintain, assess, and demonstrate. The volume of data makes analysis and interpretation time consuming. It is sometimes not as well understood and accepted as quantitative research within the scientific community. The researcher's presence during data gathering, which is often unavoidable in qualitative research, can affect the subjects' responses. Issues of anonymity and confidentiality can

present problems when presenting findings. Findings can be more difficult and time

consuming to characterize in a visual way (Anderson, 2010, pp. 3-4).

Case studies are limited by the boundaries that are set around the study

phenomenon, the information shared by participants and the possibility that the findings may not

be applicable to other case studies (Gilgun, 1994). For these reasons, this study's findings are

limited and cannot be generalized to all social workers' practices with disabled women who have

experienced MPV, due to the small number of interviews (10 participants). Email was used

instead of mail-outs to recruit participants and requests for participation may have been

forwarded by organizations to other agencies, social work faculties and departments, and

individual social workers; however, not all social workers representing all areas of practice

would have received the request for participation. My biases as a researcher and as a social

worker could have influenced the participants' responses to my questions. In particular,

participants may have sensed my desire to reinforce a positive view of social work. Some

participants were concerned about anonymity because they did not want their specific places of

work or city identified. In order to protect individual participants' confidentiality, fictitious

names were used, cities or towns and the specific names of workplaces were not identified in

relation to individual participants. Identifying the names of the specific towns or workplaces may

have provided further contextual evidence for a participant's work setting.

As there is limited existing literature on the topic of social workers' practice contexts,

their perspectives and their work with disabled women who have experienced MPV, participants

were not asked to differentiate between intersections of disabled women such as age, ethnicity,

culture, religion and types of disability. These intersections could have provided further

explanation as to why some disabled women experienced specific barriers. Another limitation

was related to social workers' recall; they might have forgotten an important aspect of practice because some participants were recalling work experiences in their social work careers that spanned over 30 years.

It was beyond the scope of this thesis to outline all Federal and Provincial Acts, programs or policies that focused on disability; however, a more comprehensive examination of Canadian policies and disabilities are available in McColl and Stephenson's (2008) review of Canadian policy.

Lastly, it was impossible to account for all of the compounding influences in the social worker's individual practice context. Influences such as a social worker's knowledge and attitude towards disabled women, the number of years of social work experience, the provincial government legislation and policies and the work setting could have affected the services that a disabled woman received; however, the availability of different resources in particular provinces or individual social workers' personal values and characteristics could have also affected social workers' practices with disabled women.

Implications and Conclusion.

This inquiry into ten social workers' perspectives, practice contexts and work with disabled women who had experienced MPV found inconsistencies in social workers' interpretations of provincial social policies. The implication of this finding is that disabled women may have received different kinds of services depending on the situation and their social worker's knowledge or willingness to circumvent government social policies. For example, social workers who were more creative and had more time to advocate might have been able to navigate the system better than social workers who were overloaded with cases or who were new to the profession and not as familiar with advocating for service users. This meant that some

disabled women could have received social services and benefits, while others might have been denied services. One way to increase consistency could be to ensure that social policies, provincial income support programs and available resources are more in line with the needs of service users to begin with. This could be accomplished by involving social workers who work in the field, along with service users, and disability organizations in the drafting of changes to existing policies, instead of relying on inadequate social policies that are likely based on efficiency and the reduction of provincial or federal government expenditures.

More precisely, provincial welfare policies have to evolve beyond the rationing of community disability services, to social welfare policies that support entitlement of community disability services, in order to ameliorate the current state of affairs (Stainton et al., 2010). Chang et al., (2003) as well as Redfern et al., (2015) have also argued that collaborative work across systems and with disability organizations is needed to improve disabled people's access to healthcare and social services.

Provincial policies might also be focused on the removal of barriers and improve the awareness of more complex types of partner abuses experienced by disabled women, a finding that was echoed by Schrottle and Glammeler (2013). These same authors proposed that barriers to services for disabled women who have experienced MPV had to be eliminated and the social construction of disability that leads to discrimination and increases in vulnerability must be abolished (Schrottle & Glammeler).

One example is how the Manitoba Disabilities Issues Office (2015) implemented a Standard for Customer Service in November 2015. This standard is to ensure that disabled people receive the same access to goods and services as non-disabled individuals (Manitoba Disabilities Issues Office). It also addresses the issue that service animals or a support person

should not be denied access or charged extra when accompanying a disabled person needing such assistance (Manitoba Disabilities Issues Office). This accessibility standard includes the removal of structural barriers (e.g., accessible buildings) and accessible customer service training of staff for organizations that have over 20 employees (Manitoba Disabilities Issues Office). While this standards policy is certainly a step in the right direction when it comes to removing barriers to customer service for disabled people, more could be done. For example, why should disabled people have to identify themselves in order to receive accessible customer service, when this is not a requirement for non-disabled people? More precisely, why can't customer service be made universally accessible?

Another finding was related to the lack of current knowledge by some social workers in women's shelters, in relation to mental health issues and to more complex types of abuses that disabled women experienced. Social workers should be required to take specialized training or education in disability (like mental health issues) and male partner violence in order to understand the complexities of disabled women's experiences of MPV. An option could be for social work students to participate in job shadowing of other professionals, who already practice with disabled women who have experienced MPV. It is possible that with enhanced knowledge, shelter staff that receives appropriate disability training or education would be more welcoming and understanding of disabled women with mental health issues. All women's shelters should be accessible and additional provincial funding should be made available to ensure that this is achieved.

Similarly, Healey et al., 2013 proposed the development of a code of standard practice for professionals such as social workers who work with disabled women who have experienced MPV. They suggested that the establishment of a specific approach to practice and research

would ensure that professionals are trained to work with disabled women and deliver consistent and effectives services (Healey et al.).

Some social workers stated that they either did not have time to advocate for disabled women or perhaps did not know what they could have done differently to help them. To address this advocacy issue, social work education programs could include an advocacy component in the curriculum or social work professional development on advocacy could be offered as part of the continuing education that social workers are required to take, for their yearly practice registration renewal. Being able to discuss advocacy strategies in workshops, might end up benefiting service users.

Another method to increase collaboration of services for disabled women would be to hold social work courses with professionals, from other disciplines such as nursing or medicine. Learning to work together as students and across disciplines could prove useful in building understanding and practice relationships. If different professionals work together to meet the needs of disabled women, individual silos and miscommunication that often complicate social workers' practices with disabled women who have experienced MPV could be reduced or eliminated.

In conclusion, findings demonstrate that social workers practice contexts are complex and reflect the uniqueness of disabled women's needs, social workers' attitudes, available resources and work settings. Some participants suggested that they were able to meet disabled women's needs by using resources from supportive mental health and disability agencies. Other social workers were left having to advocate for disabled women because of barriers such as a lack of accessible housing, transportation or work and/or other professionals' negative attitudes towards disabled women.

Findings showed that contextual elements such as education and training that shape social workers' practices could be improved and strengthened to better meet the needs of disabled women. Perhaps social workers could partner with disability activists and press governments to change social welfare policies that are unjust and exclude disabled women, from obtaining the services they need to live violence free lives. The most positive and effective contextual element was a social worker's attitude and knowledge of the system. A social worker who was knowledgeable and willing to use creativity to remove barriers was able to obtain services for disabled women who had previously been denied.

Future research could examine social workers' attitudes to determine which aspects facilitate the navigation of the system. Additional research could focus on the differences between the practices of social workers who work with women who have specific disabilities and have experienced MPV to determine their unique needs. This type of research would likely reveal that disabled women's needs are complex and require individual solutions. In the meantime, social workers and policy makers need to recognize that multifaceted safety plans should be put in place, to help disabled women leave abusive relationships. This means that accessible housing, transportation, and alternate carers need to be available when a disabled woman decides to leave her abusive male partner. It is not enough to have accessible housing, if accessible transportation is not available, as it could mean that a disabled woman, remains in an abusive relationship even longer.

Social workers will have to continue to work on the frontlines as allies of disabled women and work with policy makers to make social welfare policies more inclusive of all disabled women who experience MPV. Social workers will have to arm themselves with

knowledge and continue to passionately defend disabled women's rights to have their needs met,

until all disabled woman are safe and no longer living in violent relationships.

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Appendix A: Provincial Services

Manitoba.

In 2011 and 2012, the Manitoba Government spent nearly 14 million dollars to support a range of services such as shelters, victim services, crisis lines, counselling services, public education, and prevention programs for abused women (McInturff, 2013). In 2012, the province of Manitoba had 29 shelters or 894 spaces for women who have experienced MPV (McInturff). The Minister of Community and Family Services stated that the Manitoba Government was prepared to develop a consultation plan for a sexual assault strategy in the province (McInturff). Furthermore, the Minister responsible for disabled people at the time of this research, Tim Sale, in collaboration with the Accessibility Advisory Council of Manitoba renewed his commitment to improve the lives of disabled people with a 2015-2016 plan of action (Manitoba Disability Issues Office, 2015). This plan included raising public awareness about disabled people and barriers, overseeing the development and implementation of accessibility standards, consulting with individuals who would be impacted by these standards and ensuring that organizations are aware of their responsibilities, when it comes to accessibility (Manitoba Disability Issues Office, 2015). The Government of Manitoba had pledged to establish The Customer Accessibility Standard, as a regulation in 2015 and to extend the accessibility plan to 2023 (Manitoba Disability Issues Office). The Manitoban Legislative Act required accessibility plans, in the public sector, to be developed in collaboration with disabled people and to demonstrate how barriers would be identified, prevented, and removed, as well as measure the effects of new policies on disabled people (Manitoba Disability Issues Office). The potential impact of this legislation means that disabled people would have the opportunity to voice their perspectives, on specific barriers that obstruct their full participation in society and offer concrete solutions that

are more apt to meet their needs. It is reasonable to say that the collaboration between disabled people and policy makers is necessary, in order to understand what is required to remove or prevent the establishment of barriers that create accessibility issues in Manitoba.

Saskatchewan.

The province of Saskatchewan had male partner violence legislation but, did not have a specific provincial action plan, to reduce intimate partner violence or sexual violence (McInturff, 2013); despite the fact that Statistics Canada (2011) reported that the province of Saskatchewan had more than double the rate of male partner violence incidents, compared to the rest of the provinces (Statistics Canada, 2013a). In 2012, the province of Saskatchewan had 26 shelters including seven second stage houses for abused women who have left their partners, and two emergency shelters (McInturff). The 2011-2012 budget in Saskatchewan for male partner violence and child abuse programs and services was 9.3 million dollars (McInturff). The lack of a specific action plan to reduce male partner violence, especially as it concerns disabled women is an indication that more needs to be done to raise awareness. The Office of Disability Issues (2015) reported that the Saskatchewan Government's 2015-2016 budget included 23 million dollars of funding towards program utilization for disabled people such as income support, tax benefits and community inclusion.

Ontario.

The province of Ontario had both a sexual violence action plan and a domestic violence action plan (McInturff, 2013). As part of the 2011-2012 sexual violence and domestic violence action plan, the Government was committed to spending 188 million dollars on services (McInturff). In 2012, the Province of Ontario had 171 shelters including 57 transition homes, 36 second-stage housing shelters, 33 emergency shelters, 31 women's emergency centers, eight

family resource centres, and six other types of shelters (McInturff). The Office of the Auditor General of Ontario[1] (2013) reported that the monitoring of violence against women services was lacking; for instance, the Ontario Ministry of Community and Social Services had not developed any guidelines or standards when it came to the delivery of violence against women services, such as setting staffing levels or admission criteria for women's shelters. This lack of monitoring could make it difficult to know what exactly is required to meet the needs of women and disabled women, who are accessing these services.

In 2005, Ontario was the first province and one of the first jurisdictions in the world to enact specific legislation for accessibility and continues to expand its plan to promote inclusion and accessibility of disabled people by focusing on employment, customer service, transportation, communication, and accessible designs in public spaces, well into the year 2025 (Government of Ontario, Economic Development, Employment and Infrastructure, 2016).

Prince Edward Island.

On a different note, McInturff (2013) stated that in 2012, Prince Edward Island, Family Violence Services provided support for emergency shelters and transition housing, a 24 hour crisis line, outreach services, public education and community support services for those affected by family violence (including violence against children and seniors). The Province of Prince Edward Island had four shelters including two emergency shelters and two second stage housing shelters (McInturff). This government spent nearly 900,000 dollars on service organizations in 2011–12 (McInturff). The Premier's Action Committee on Family Violence Prevention was established in 1995 "to provide education and awareness about family violence prevention and to implement and promote a provincial family violence prevention strategy" (McInturff, 2013, p. 25).

McInturff's (2013) report on the Province of Prince Edward Island's effort to reduce male partner violence against women did not include any specific services aimed at disabled women who had experienced male partner violence.

This omission could be an indication that the Province of Prince Edward Island did not have a strategy to address the more complex needs, of disabled women who have experienced male partner violence. It is important to identify existing gaps in the delivery of specific services to disabled women who have experienced MPV because it shows where the government could focus its future initiatives.

The Prince Edward Island Department of Family and Human Services published an online document in 2016, "Canada – Prince Edward Island Labour Market Agreement for Persons with Disabilities" renewing their commitment to disabled people by prioritizing areas such as education and training of disabled people, employment inclusion, building knowledge on labour policies and disability and by connecting employers with disabled people

Nova Scotia.

In 2012, the Province of Nova Scotia had 18 shelters available for women who had been abused; this included 12 transition homes, five second stage shelters, and a crisis shelter (McInturff, 2013). In Nova Scotia, the Advisory Council on the Status of Women oversaw the partner violence plan and in 2011-2012, the Provincial Government spent over 6 million dollars to fund programs such as prevention, education, risk assessment, policing, prosecution, counseling, and support services (McInturff).

Whether these services were accessible and met the needs of disabled women who had experienced MPV, is not clear because disabled women were not specifically identified as service users in the report.

It is uncertain how these government policies have impacted disabled women who had experienced male partner abuse, because they were not necessarily aimed at improving accessibility, awareness, or to provide programs specifically for disabled women instead, they seemed to be aimed at addressing the needs of non-disabled women, who had experienced MPV.

At the time of this current research, the Nova Scotia Government, Community Services (2015) was moving towards Accessibility Legislation in 2016; priority areas included employment, transportation, client services, housing, attitudes and public awareness, as well as improving accessible communication.

_____

[1]The Office of the Auditor General of Ontario did produce a report in 2014 however, the focus was on offenders.

Appendix B: Research Instrument Guide (March 29, 2014)

Demographic Questions

1. How many years have you been practicing as a social worker?

2. How old are you?

3. How many years have you been working with disabled women who have experienced male partner violence?

4. When did you start working with them?

5. What type of types of setting (s) are you or did you work in when you worked with disabled women who had experienced male partner violence? Is this a city or rural?

6. What type of work did you do there …your practice experience?
   Can you tell me more…

7. Approximately how many people work in this setting?

8. What is your educational background?

9. Did you receive any specialized training or education to work with disabled women who have experienced male partner violence?
   Can you tell me more about these courses? Can you tell me about your training?

Research Open-ended Questions

1. As a social worker how do you define disability?

2. Would you say that your definition is the same or different to where you are working or worked?

3. Can you tell me more about your work environment, maybe their policies, programs, legislation? Also, theories or models you might have used with disabled women who had experienced male partner violence.

4. How has the work environment affected or not affected your practice experience?

5. In your practice, would you say that violence that disabled women experienced could be described as the same or different than nondisabled women?

   Tell me more…

6. How would you as a social worker describe your practice experience with disabled women who have experienced male partner violence?

7. Can you tell me more about your practice – about barriers, accessibility, or resources that were helpful; can you describe these in more detail; can you give me examples?

8. How do you see social workers advocating for disabled women? How have you had to advocate for disabled women?

Would you like to add anything else that what not discussed in the questions but that is related to your experiences with disabled women who have experienced male partner violence?

Appendix C: Approval Certificate

UNIVERSITY
OF MANITOBA | Research Ethics and Compliance
Office of the Vice-President (Research and International)

APPROVAL CERTIFICATE

April 22, 2014

TO: **Claire Fleet**   (Advisor T. Heinonen)
Principal Investigator

FROM: **Jacquie Vorauer, Chair**
Psychology/Sociology Research Ethics Board (PSREB)

Re: **Protocol #P2014:030**
**"A Critical Inquiry into Social Workers' Roles, Practices, and Models in
Relation to Disabled Women who Have Experienced Male Partner Violence"**

Please be advised that your above-referenced protocol has received human ethics approval by
the **Psychology/Sociology Research Ethics Board**, which is organized and operates
according to the Tri-Council Policy Statement (2).   It is the researcher's responsibility to
comply with any copyright requirements.   **This approval is valid for one year only**.

Any significant changes of the protocol and/or informed consent form should be reported to the
Human Ethics Secretariat in advance of implementation of such changes.

Please note:

-    If you have funds pending human ethics approval, please mail/e-mail/fax
(261-0325) a copy of this Approval (identifying the related UM Project Number) to the
Research Grants Officer in ORS in order to initiate fund setup.   (How to find your UM
Project Number: http://umanitoba.ca/research/ors/mrt-faq.html#pr0)

-    if you have received multi-year funding for this research, responsibility lies with
you to apply for and obtain Renewal Approval at the expiry of the initial one-year
approval;   otherwise the account will be locked.

The Research Quality Management Office may request to review research documentation from
this project to demonstrate compliance with this approved protocol and the University of
Manitoba Ethics of Research Involving Humans.

The Research Ethics Board requests a final report for your study (available at:
http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) **in order
to be in compliance with Tri-Council Guidelines.**

Appendix D: Amendment Approval

UNIVERSITY
OF MANITOBA | Research Ethics and Compliance
Office of the Vice-President (Research and International)

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone +204-474-7122
Fax +204-269-7173

AMENDMENT APPROVAL

May 27, 2014

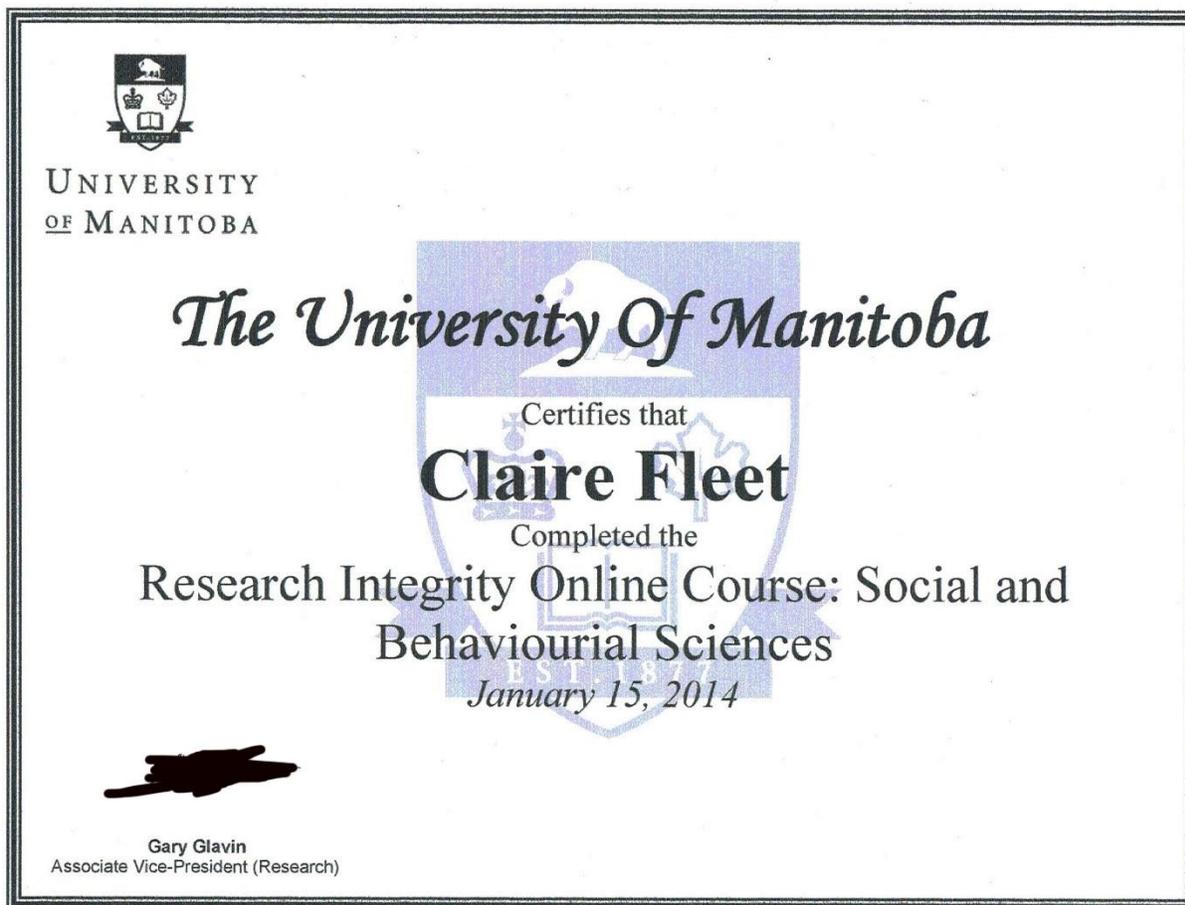**TO:**   **Claire Fleet**
Principal Investigator

FROM: Jacquie Vorauer, Chair
Psychology/Sociology Research Ethics Board (PSREB)

Re: **Protocol #P2014:030
"A Critical Inquiry into Social Workers' Roles, Practices, and
Models in Relation to Disabled Women who have Experienced
Male Partner Violence"**

This will acknowledge your request dated May 27, 2014 requesting amendment to the above-noted protocol.

Approval is given for this amendment. Any further changes to the protocol must be reported to the Human Ethics Secretariat in advance of implementation.

Appendix E: Research Integrity

UNIVERSITY
OF MANITOBA

The University Of Manitoba

Certifies that

Claire Fleet

Completed the

Research Integrity Online Course: Social and
Behaviourial Sciences

January 15, 2014

Gary Glavin
Associate Vice-President (Research)

Appendix F: TCPS2 Core Certificate

PANEL ON
RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Claire Fleet

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **11 April, 2014**

Appendix G: Consent Form

Consent Form

Project title: A Critical Inquiry into Social Workers' Perspectives, Theories, Models and

Practice Contexts Related to Disabled Women Who Have Experienced Male Partner Violence

Principal Investigator: Claire Fleet, PhD candidate, Faculty of Social Work, University of Manitoba

Research Supervisor: Dr. Tuula Heinonen, Professor, Faculty of Social Work, University of Manitoba

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

You are being invited to be interviewed by the principal investigator (researcher) regarding your experiences as a social worker who has worked with disabled women who have experienced male partner violence. This research is being conducted by Claire Fleet as part of her dissertation, under the supervision of Dr.Tuula Heinonen at the University of Manitoba. The primary goal of the project is to better understand the perspectives and practices of social workers in relation to disabled women who have experienced male partner violence. Interviews will be held during the day in any location that provides reasonable privacy and is agreeable to both of us. The interview is not expected to exceed 1.5 hours in length.

You will be asked a series of questions about your perspectives and practices with disabled women. Questions will be focused on describing your perspectives and practice with disabled women who have experienced partner violence. However, you will be encouraged to share your experiences in whatever manner is most comfortable for you. The interview will be audio recorded.

A $10.00 gift card will be provided to you as an honorarium. Even if you decide to stop participating at any time during the interview process, you will receive the honorarium.

Please note that recalling your practices with disabled women who have experienced male partner violence might trigger uncomfortable feelings related to your experiences. Given this possibility, as a participant you may stop participating in the interview at any time. Should you wish to talk to someone during or after the interview, one option is to contact Klinic's crisis line or your local crisis line.

Following the interview, I may need to contact you for further information or clarification and this would only involve brief conversations over email or telephone. This contact will be optional and I will ask separately for your consent to do so. At the end of the study, which may be in the fall of 2014, you will have the option of receiving *a* brief summary of the findings.

At the end of the study, I will be presenting my findings to my committee. In addition, I may attempt to publish my findings or presenting them at professional conferences. However, in all cases I will do so without revealing identifying characteristics such as names, addresses, and specific employment details. Nonetheless, there is a risk that someone may identify you through the information that you are providing. I will only use quotations from the interviews after removing identifying details, so they cannot be attributed to any single person.

The only persons who will have access to information collected in the project are my research supervisor and me. All information will be kept strictly confidential. Documents related to the interviews will be stored on my password-protected personal computer. Tapes and hand-written notes, if any, will be stored in a locked cabinet in my home. I will transcribe interviews and, in the process, remove all personal identifiers. All documents will be shredded and/or deleted one year later, in the fall of 2015.

If during the course of the interview you inform me of abuse against children or persons in care, by law, I am obligated to report it to legal authorities.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate. In no way does this waive your legal rights nor release the researcher from her legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

This research has been approved by the University of Manitoba Psychology/Social Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

If you agree to each of the following, please place a check mark in the corresponding box. If you do not agree, leave the box blank:

I have read or had read to me the details of this consent form. ()
My questions have been addressed. ()
I, _____ (print name), agree to participate in this study. ()
I agree to have the interview audio-recorded. ()
I agree to be contacted by phone or e-mail if further information is
required after the interview ()
I agree to have the findings (which may include quotations) from this
project published or presented in a manner that does not reveal
my identity. ()
Do you wish to receive a summary of the findings? () Yes () No
How do you wish to receive the summary? () E-mail () Surface mail

Address or E-mail: _____

Participant's Signature _____ Date _____

Researcher's Signature ___Claire Fleet_____ Date _____June 3r, 2014_____

Appendix H: Email to Organizations and Faculties of Social Work (Across Canada)
March 07, 2014

My name is Claire Fleet and I am a graduate student from the Faculty of Social Work at the University of Manitoba and for my dissertation research "A Critical Inquiry into Social Workers' Roles, Practice Contexts, Theories, Models and Approaches in Relation to Disabled Women Who Have Experienced Male Partner Violence". I am looking for social workers who have worked with disabled women who have experienced male partner violence. Please share the attached request with social workers in your organization/faculty. I appreciate your help!

Appendix I: Poster

Attention Social Workers

My name is Claire Fleet and I am a graduate student from the Faculty of Social Work at the University of Manitoba and for my dissertation research "A Critical Inquiry into Social Workers' Roles, Practices, Theories and Models in Relation to Disabled Women Who Have Experienced Male Partner Violence", I am looking for social workers who are currently or have worked with disabled women who have experienced male partner violence, to participate in an approximately one to one and a half hours face to face/telephone interview to answer a few open-ended questions on their experiences, perspectives, and/or practices used with disabled women. This research is necessary and valuable to improve our understanding of disabled women's needs and to determine how we can improve our collaboration with disabled women who have experienced male partner violence.

A $10.00 gift card will be provided as honorarium. To ask questions or to volunteer to participate please contact me at

Research Supervisor: Dr. Tuula Heinonen, Professor, Faculty of Social Work, University of Manitoba. This research has been approved by the University of Manitoba Psychology/Sociology Research Ethics Board.

Appendix J: Email to Participants

March 27, 2014

Email response to participants who emailed me as a result of recruitment poster (across Canada)

Hello Ms/Mr,

Thank you for responding to the recruitment poster and being interested in my research. If you are currently working or have in the past worked with disabled women who have experienced male partner violence, I would be interested in talking with you to hear about your experiences. Please let me know if you have any questions and perhaps a couple of dates and times that would be convenient. Also, did you have a preference for a place where you would like to meet or telephone number where you may be reached? Please see attached consent form that you would be required to sign and return to me by email before the interview, should you decide to participate.

I look forward to hearing from you, thank you,

Claire Fleet

Appendix K: Interview Script

Thank you for taking the time to answer some questions about your practice with disabled women who have experienced male partner violence and for signing and emailing me your consent form. Before I start, do you have any questions? And just a reminder that you can stop the interview at any time, or refuse to answer any of the questions and you will still receive the $10.00 gift card. If at any time during the interview you feel uncomfortable about a question please let me know and you don't have to answer. Also, a reminder that Klinic in Manitoba provides telephone counselling or your local crisis line should you wish to speak with someone.

Appendix L: Email to Participants Asking Them to Review Transcripts and Provide

Comments or Questions if Desired

Hello,

Attached you will find a transcript of our interview conversation. Please let me know if you would like me to change any part of it, if it fine the way it is or if you have any questions. I appreciate your time and participation.

Claire Fleet