Self-Defense Among Women With Disabilities : An Unexplored Domain in Domestic Violence Cases

Michelle S. Ballan and Molly Burke Freyer

Violence Against Women 2012 18: 1083 originally published online 20 September 2012
DOI: 10.1177/1077801212461430

Article

Self-Defense Among Women With Disabilities: An Unexplored Domain in Domestic Violence Cases

Violence Against Women
18(9) 1083–1107

DOI: 10.1177/1077801212461430
http://vaw.sagepub.com

Michelle S. Ballan[1] and Molly Burke Freyer[2]

Abstract

Women with disabilities are frequent victims of domestic violence, yet scant research has examined self-protective mechanisms that could mitigate this abuse. This article reviews prevalence and types of intimate partner violence against women with disabilities and explores the factors that leave this population at higher risk for abuse than nondisabled women. Barriers to self-protection against domestic violence for women with diverse disabilities are highlighted and the use of nonfatal force as self-defense is explored. A case example and considerations for enhancing self-protection strategies for women with disabilities experiencing intimate partner violence are provided.

Keywords

disabilities, domestic violence, interpersonal violence, self-defense, women

A small but growing literature on the abuse of women with disabilities has established that this population experiences violence at disproportionate rates relative to the general population. Women with disabilities are more likely to be abused than both women without disabilities and men with disabilities, and for longer periods of time (Brownridge, Ristock, & Heibert-Murphy, 2008; Casteel, Martin, Smith, Gurka, & Kupper, 2008; Cohen, Forte, Du Mont, Hyman, & Romans, 2005; Martin et al., 2006; Smith, 2008). Violence against women with disabilities is not simply a subset of gender-based violence; it is an intersectional category dealing with gender-based and disability-based violence resulting in an

[1]Columbia University, New York, NY, USA
[2]New York University, New York, NY, USA

Corresponding Author:
Michelle S. Ballan, Columbia University, School of Social Work, 1255 Amsterdam Avenue, New York, NY 10027, USA
Email: msb2008@columbia.edu

elevated risk to violence for women with disabilities (International Network of Women with Disabilities, 2010). Given the prevalence of violence against women with disabilities, it is surprising that the topic has received minimal attention in the scholarly literature (Chang et al., 2003), with an even greater paucity of research on women with disabilities who experience violence by an intimate partner.

Research on the strategies women with disabilities have developed to protect themselves during incidents of domestic violence is just emerging. The use of violence as self-defense has been largely unexplored as a self-protective behavior for this population. This article assumes that the male perpetrator and female victim with disabilities are or were formerly in an intimate heterosexual relationship. It reviews the prevalence and types of intimate partner violence against women with disabilities and examines this group's risk factors for abuse. From this foundation, the article explores physical and intellectual vulnerabilities as challenges to self-protection against domestic violence and includes an illustrative case example. Finally, considerations regarding self-protection strategies for women with disabilities experiencing intimate partner violence are explored.

Prevalence and Types of Domestic Violence

Domestic violence is a widespread social problem affecting up to 54% of adult women with disabilities (Carlson, 1998; Coker, Smith, & Fadden, 2005), with husbands and live-in male partners as the most common perpetrators of physical, emotional (Milberger et al., 2003), and sexual abuse (Martin et al., 2006). The Colorado Department of Health provided an even higher estimate, citing that upward of 85% of women with disabilities are victims of domestic abuse in comparison with, on average, 25% to 50% of the general population (Feuerstein, 1997). Canadian research with 7,027 women living in marital or common law unions revealed that women with disabilities had a 40% greater likelihood of intimate partner violence in the 5 years preceding the study than nondisabled women. Women with disabilities were two times as likely to report severe abuse, including being beaten, kicked, bitten, or punched, and three times more likely to report being forced into sexual activity by being held down, threatened, or hurt in some way (Brownridge, 2006). Because severity of violence can have a profound adverse effect on the health and well-being of women with disabilities, it is understandable that this population ranks issues of violence as their most important research and health priorities (Curry, Hassouneh-Phillips, & Johnston-Silverberg, 2001).

Intimate partner violence is a serious public health concern as well as a violation of human rights (Grande, Hickling, Taylor, & Woollacott, 2003; Uno, Ui, & Aoyama, 2004). Intimate partner violence, also referred to as domestic violence, is typically thought to include behaviors intended to exert power and control over another individual, including physical, sexual, verbal, emotional, or financial abuse. However, there is not a single broad definition of domestic violence that embodies all forms of violence that women with disabilities suffer. The literature on disability and abuse has uncovered additional types of intimate partner violence unique to women with disabilities. These include restraint and control; withholding or sabotaging needed equipment and adaptive communication aids

(e.g., wheelchairs, facilitative communication board), medications, and transportation; withdrawing essential assistance with personal tasks, such as dressing, toileting, or getting out of bed; and being left in physical discomfort or embarrassing situations for long periods of time (Nosek, Howland, Rintala, Young, & Chanpong, 2001; Saxton et al., 2001). Some of these disability-related forms of violence are permissible by law.

Abusive intimate partners exploit the challenges presented by the disability, knowing that this will seriously limit a woman's ability to take action (Beck-Massey, 1999; Nosek, Clubb Foley, Hughes, & Howland, 2001). Gilson, Cramer, and DePoy (2001) speak to the manner in which disability can transform abuse, using the example that a woman who does not have a disability may experience emotional abuse when a perpetrator makes her afraid of accessing certain needs such as using the bathroom, while a woman with a disability may consider the same act to be physical abuse if she generally requires her partner's assistance to meet this need. In another study, a woman spoke of abuse causing her to feel "more disabled than I have to be" (Cramer, Gilson, & DePoy, 2003, p. 192), underscoring how abuse compounds the challenges posed by one's disability.

Risk Factors for Domestic Violence

Risk factors for intimate partner violence among women with disabilities are similar to those of nondisabled women but also include situational factors related to women's specific disabilities (Nosek, Howland, & Hughes, 2001). Life circumstances of women with disabilities, including reduced community inclusion or social isolation and a deeper dependence on intimate partners for assistance with daily needs (Copel, 2006), may heighten their potential for victimization at the hands of an intimate partner as compared to other women. If a perpetrator assists with the woman's execution of activities of daily living such as hygiene or food needs, she may be forced to choose between having these vital needs met, or reporting the abuse and losing reliable, albeit abusive, assistance (Saxton et al., 2001). A partner may manipulate the power dynamic in this relationship, encouraging dependency rather than self-determination in his partner, as he is aware that her vulnerability will be heightened as a result (Curry et al., 2001). Within a framework of power and control, some men may view female partners with disabilities as less difficult to dominate, and thus target them (Brownridge, 2006).

Social messages about disability have a significant impact on a woman's self-esteem and beliefs about the kind of relationship she deserves. Hassouneh-Philips and McNeff (2005) interviewed 75 women with physical disabilities and found that those with more serious disabilities, such as spinal cord injury, were more likely to perceive themselves as sexually inadequate and unattractive than women with less pronounced disabilities. This negative self-perception, coupled with a strong desire to be in an intimate relationship, increased a woman's vulnerability to staying in an abusive relationship with her partner. Furthermore, the stereotype that a woman with a disability is "damaged goods," and thus not someone who would be valued as an intimate partner, fuels the myth that anyone willing to be with a woman with a disability must be a "saint," and thus incapable of abuse (Wisseman, 2000). Also, women with disabilities are taught to be compliant and discouraged

from being assertive. This compliance, which is encouraged solely to ease the caregiver's role, can reduce the likelihood that a woman with a disability will speak out against her abusive partner (Sobsey, 1994).

Women with disabilities may face what Chenoweth (1996) refers to as "double discrimination," that is, discrimination based on one's gender and disability. Such discrimination is rooted in issues of sexism and ableism, and has implications for the independence of women with disabilities. Contending with patriarchy and ableism, in addition to other forms of intersecting discrimination (e.g., race, class, age, and sexualities), women with disabilities experiencing domestic violence are younger, less likely to be married and have lower incomes (Barrett, O'Day, Roche, & Carlson, 2009). Women with disabilities are disproportionately poorer than the general population (Hassouneh-Philips, McNeff, Powers, & Curry, 2005), a result of their secondary social status, which exacerbates the hardship of gaining economic independence from an abuser. Economic independence has a great impact on a woman's ability to escape an abusive relationship. Knowing that economic independence is a key factor in one's ability to leave an abusive relationship, perpetrators may steal a woman's savings, social security checks, or other income available to her (Beck-Massey, 1999).

Furthermore, an abuser may threaten a woman with a disability with placement in a nursing home or the loss of custody of her children if she reports the abuse (Beck-Massey, 1999). Although leaving an abuser may result in greater independence, for women with disabilities escape from an abusive relationship can result in loss of independence, including possible institutional care, in the absence of a caretaker (Curry et al., 2001).

If a woman with a disability chooses and is able to report abuse, she may have great difficulty accessing support services such as domestic violence agencies or the police, due to isolation, physical and attitudinal barriers among service agencies and providers, and fear of retribution by the abuser (Chang et al., 2003; Radford, Harne, & Trotter, 2006). When a woman cannot physically enter a shelter or agency due to architectural inaccessibility, she is simply deprived of the help available to those without disabilities and is at an increased risk for sustained abuse by her partner. Finally, even if a woman with a disability does contact a domestic violence agency for assistance, she may be diverted to a disability services agency when she reveals her disability. Her disability rather than the abuse she has suffered is mistakenly viewed by service professionals as the main treatment need (Cramer et al., 2003). In this way, disability status can be an obstacle to appropriate care. Similarly, societal perceptions and responses to disability can also become an impediment to the criminal justice process when testimony from a woman with a disability is not accepted as credible, due to pervasive myths and stereotypes about her motives and intellectual capacities (Mitchell & Buchele-Ash, 2000).

Vulnerability as a Risk Factor

The vulnerability of women with disabilities is often discussed as a risk factor for intimate partner violence. The use of the word "vulnerable" may falsely imply that women with disabilities are abused at a higher rate simply because they are disabled. The concept of

vulnerability is complex, however, and focusing narrowly or superficially on it as a risk factor can obscure the fact that women with disabilities are not just subject to heightened danger due to their disability status.

Women with disabilities describe several disability-related factors that increase their vulnerability to abuse and the challenges of escaping it. These include (a) architectural barriers and transportation inaccessibility; (b) dependence on perpetrators for essential caregiving, such as eating or transferring from a wheelchair to the toilet; (c) lack of adaptive equipment in shelters; (d) shelter restrictions against service animals or caregiver's lodging; (e) and social stereotypes of women with disabilities as passive and helpless (Hassouneh-Philips & Curry, 2002; Magowan, 2003). Vulnerability also results from the lack of attention and support services available to battered women with disabilities.

Comparative studies of risk factors for partner violence among women with disabilities and women without disabilities would help to determine whether this vulnerability is compounded by disability or other factors (Nosek, Hughes, Taylor, & Taylor, 2006). Other potentially relevant factors include race and ethnicity, gender, age, educational level, and socioeconomic status. Prevalence studies should include these characteristics in analyses (Lightfoot & Williams, 2009). Women with disabilities are often disadvantaged by structural inequities related to race, gender, and other sociocultural factors of oppression that operate in complex and fragmented ways (Nixon, 2009). Thus as Powers et al. (2009) suggest, it is the social context of disability that increases women's vulnerability to intimate partner abuse and adds to the challenges women face while doing their best to address it. Safety promotion strategies, such as self-defense, have unique meanings and functions for women with disabilities.

Self-Defense as a Protective Strategy

If a woman's use of violence is motivated by self-defense, and thus legally justifiable, this can be interpreted as an indication of her entrapment in an abusive relationship and her need for help. In fact, passive and active forms of self-defense are among the many strategies women employ to escape, avoid, and protect themselves against intimate partner abuse (Dutton, 1992). However, the actual effectiveness of both physical and nonphysical self-defense methods has mixed support in the extant literature on self-defense for female survivors of violence. Major points of contention include whether physically resisting an abuser can actually increase the possibility of injury, and the differences between the use of self-defense during intimate versus nonintimate partner attacks. Several studies have attempted to shed light on these questions, many of which have utilized data from the National Crime Victimization Survey (NCVS) that surveys approximately 101,000 individuals, ages 12 and older, annually (Bachman, Lachs, & Meloy, 2004). Of these studies, several determined that women were at greater risk of injury when resisting an intimate partner than when resisting a stranger (Bachman & Carmody, 1994; Bachman et al., 2004; Thompson, Simon, Saltzman, & Mercy, 1999). Conversely, Ruback and Ivie (1988) found that physically resisting a rapist who was a stranger resulted in a greater likelihood of injury than when resisting a rapist who was known to the victim. Clay-Warner (2002)

likewise determined that women who physically resisted during a rape had the greatest chance of avoiding rape completion as opposed to those who used verbal, nonphysical protective actions.

What studies to date have not been able to determine is whether physical resistance may have prevented greater harm from occurring to the victim, despite the fact that the victim was injured while resisting. For instance, Bachman and Carmody (1994) found that in stranger-perpetrated crimes of violence, forceful physical resistance resulted in a greater risk of injury, but also resulted in the crime being completed less often. And while Thompson et al. (1999) determined that women defending themselves against intimate partners were more likely to be injured than unknown offenders, 57% felt that using self-protective measures was helpful in avoiding greater injury. As Clay-Warner (2002) noted, the NCVS data have some limitations, including the fact that women who were killed in the process of an assault are obviously not included in the survey, making it impossible to determine what types of defense methods were, or were not, used. For women who were injured in the process of resisting an intimate partner, it is possible that they may have prevented a graver injury, or even death, had they not defended themselves.

Madden and Sokol (1997) note that some studies indicate women are more likely to resist attackers when injured, as opposed to women more often becoming injured due to resisting. This illuminates another issue with NCVS data: The sequence of protective measures is not specified, making it impossible to determine whether a woman began to fight back only after becoming injured and may have ended a potentially fatal attack by doing so (Clay-Warner, 2002). Previous analysis of the NCVS data indicated that women who utilized self-protection methods, both physical and nonphysical, had a decreased chance of experiencing completed rape, but were also at increased risk of physical injury (Marchbanks, Lui, & Mercy, 1990). However, of those women who were injured, 80.7% reported injuries consisting of bruises, cuts, scratches, or swelling, raising the question of whether these more minor injuries may have been sustained in prevention of more serious injuries (e.g., broken bones, gunshot wounds).

Most domestic violence empirical studies typically exclude women with disabilities from the sample, especially those with disabilities that may impede their ability to employ nonviolent self-defense techniques, such as physically escaping the situation or calling upon formal or informal networks of support. For women with disabilities, self-defense may be a harm-reduction tactic. A woman with disabilities may recognize signs that her partner is on the verge of violence and use violence against him first, for the purpose of trying to gain immediate control of the situation (Hamberger & Guse, 2002). This preemptive strike is different from a woman's initiation of violence in that she is responding to what she believes is an imminent threat to her safety (Downs, Rindels, & Atkinson, 2007).

Such actions highlight the importance of considering the context in which female violence against a male perpetrator may occur, as it is most often a self-defense tactic rather than violence intended to control or harm one's partner (Swan, Gambone, Caldwell, Sullivan, & Snow, 2008). In this case, the use of force by women can be seen as a survival skill that can be cultivated to assist women in protecting themselves. Swan and Snow (2002) note that women's physical self-defense efforts generally fail to control the

behavior of their abusive male partners and do not inspire fear. These data suggest that the tactics are not being executed effectively. The remedy to this may lie in self-defense training for women, as the skills taught in these classes show promise for reducing risk of violence and enhancing one's ability to resist assault (Hollander, 2004).

Madden and Sokol (1997) question whether physical resistance would be more effective if women were better trained in self-defense skills. While women's bodies are, on average, smaller than those of men, certain physical tactics have been shown to be vastly more effective than others in resisting men. For instance, hitting an offender in the groin with a cane will do much greater damage than attempting to hit him with one's hands. If a woman has not been trained to use this tool, however, she may continue to use a less effective form of self-protection in an assault and thus be at greater risk of harm. There may be instances in which verbal resistance is more effective than physical resistance and vice versa. In some extreme cases, physically disabling the perpetrator and fleeing may be a woman's only chance of survival. At other times, attempting to verbally de-escalate the situation may be more appropriate. A comprehensive self-defense class could provide the opportunity for women to learn how to differentiate between the two situations.

Given the general recognition that intimate partner violence is a serious social ill and the knowledge that self-defense skills can mitigate the risk of violence, why has the topic of self-defense been sorely neglected in the literature and in the formulation of safety plans for women with disabilities? It could be due to others' beliefs regarding the abilities of women with disabilities, such as assuming that a woman with a serious disability may not be able to physically fight back or walk away from a potentially harmful situation, or that a woman with communication impairment may be unable to tell people what is happening to her. The exclusion of women with disabilities from the self-defense literature could also represent a failure to consider the challenges presented by disability, such as neglecting to modify safety plans to make provisions for a woman who is dependent on her abuser for assistance with basic needs (Erwin, 2000). Finally, this could be the result of socially ingrained myths regarding the capabilities of women with disabilities, as women with disabilities themselves may have been led to believe that they are incapable of defending themselves or shielding themselves from harm (David, Kollmar, & McCall, 1998). These factors, among others, must be explored when examining the dynamics of the challenges and limitations of self-protection among domestic violence survivors with disabilities.

Ability Challenges to Self-Protection

A woman's capacity to protect herself from an abusive intimate partner varies with the nature of her disability. Complications presented by the disability may make fighting back and escape difficult, if not impossible (Barranti & Yuen, 2008). Women with disabilities tend to stay in abusive relationships for longer periods of time than women without disabilities (Smith, 2008), due in part to the fact that certain disabilities make it especially difficult to verbally report the abuse, run from, or fight their abuser (Petersilia, 2000). Furthermore, constant denigration by the abuser may reinforce a woman's belief that she cannot control her situation, thus contributing to the problem's chronicity

(Brodwin & Siu, 2007). Acquisition of self-protection skills would have a positive impact on the safety and well-being of women with disabilities in intimate partner relationships, but this topic is rarely explored with survivors and there are scant resources available. A brief introduction of the barriers to self-protection skills development among women with physical, sensory, developmental, psychiatric, and invisible disabilities is outlined below. Elaborating the full range of barriers for individuals with disabilities is beyond the scope of this article.

Physical disabilities. Disabilities affecting mobility or physical ability to fight back pose challenges to defending oneself against abuse. Based on a series of interviews with women with disabilities, Mays (2006) discovered that while several women did attempt to defend themselves, the majority concluded that self-defense was "useless," noting, "Many of the women resigned themselves to the abuse, indicating 'I just had to take it and get it over with'" (pp. 119-120). It seems likely that the women interviewed may have been voicing reinforced social myths regarding their capabilities reified by the abuser. Alternatively, they may have been expressing frustration at the lack of options they had in resisting the abuser. Some physical disabilities, such as those significantly impacting motor coordination or strength, may make forceful resistance difficult or unadvisable. Indeed, there may be certain situations in which complying with a perpetrator is the safest tactic, such as when a weapon is being used or if multiple offenders are present (Madden & Sokol, 1997). Nonphysical forms of resistance, including reasoning with the offender, calling for help, or screaming and yelling, may at times be more effective than either not resisting at all or physically resisting both intimate partner and stranger offenders (Bachman et al., 2004). This indicates that teaching women nonphysical self-defense methods could be an integral component of a safety plan, as responding to the violence in this manner may be safer than doing nothing. If a variety of self-protection skills were taught to women with physical disabilities, perhaps the notion that defending oneself against abuse is "useless" would be less prevalent.

Opportunities to take advantage of self-defense resources, such as workshops and classes, are limited for women with disabilities due to the social isolation often accompanying both disability and abuse. Moreover, research has documented the inaccessibility of domestic violence programs as a major impediment to help-seeking among women with disabilities (Milberger et al., 2003; Saxton et al., 2001; Swedlund & Nosek, 2000). Inaccessibility manifests in various forms, including structural barriers to entering and navigating a facility such as stairs or narrow doorways, and attitudinal stereotypes as well as presumptions about the abilities and inabilities of women with physical disabilities. Beyond physical inaccessibility, a lack of knowledge regarding the needs of women with disabilities has a significant impact on the interventions service providers offer. Strategies utilized in traditional safety skill building curricula, for example, may not consider the needs of a woman who depends on her abuser to assist her in getting out of bed in the morning (Erwin, 2000). Furthermore, women with physical disabilities may assume that self-defense classes geared towards non-disabled women will not include modifications of techniques taking disability into account. If classes with such modifications are available, instructors should make this clear in advertisements in order to reach a more diverse audience.

Sensory disabilities. Not being able to see or hear one's abuser presents a clear risk to personal safety, yet very few resources exist regarding self-defense for individuals with sensory disabilities. One exception is David et al.'s (1998) *Safe Without Sight*, which describes prevention and self-defense tactics for individuals who are visually impaired. This book acknowledges the challenges of vision impairment. An individual with limited sight will have difficulty determining if she is being followed around her home, approached unexpectedly, or videotaped while dressing or bathing, and has limited access to self-defense books and classes. However, the authors view self-defense as a practical and necessary skill that should be cultivated among women with sensory disabilities: "Self-defense is not solely about strength or mobility. Rather, self-defense is a state of being, a 'mindset.' It is a practiced way of thinking about your safety and choosing to assert and protect your physical boundaries" (David et al., 1998, p. 41). In a survey of 161 individuals with visual impairments, women who had attended a seminar on self-defense were more confident in their ability to defend themselves if assaulted, yet only half of the study population reported receiving any previous self-defense training (Pava, 1994). Accordingly, the provision of more widely accessible resources, including self-protection skills training with techniques adapted for women with varying degrees of vision, is critical.

For individuals who are deaf or hard of hearing, accessibility of resources is also a major problem. Without sign language interpreters, for example, self-defense courses may not be a worthwhile option for those who communicate using American Sign Language (ASL). Furthermore, communication styles vary widely among individuals who are deaf. While ASL is the preferred mode of communication for some, others lip-read and write, or have minimal language skills that require more visual or demonstrative forms of communication (Taylor & Gaskin-Laniyan, 2007). Individual communication abilities need to be taken into account during the development of self-protection resources for the Deaf community.

Abusers will exploit the fact that a woman with visual or auditory challenges is unable to see or hear an impending attack and will target her. Individuals with sensory disabilities can learn skills to protect themselves against such attacks. Service animals can also be used strategically to protect women with disabilities; they can be trained to detect a partner's imminent attack and forewarn, activate an alarm system, or appear menacing to the abuser (Hoog, 2004). The use of a service animal as a means of self-protection in a dangerous situation may very well be one of the best survival tools a woman with a disability has at her disposal and could prove a vital component of a personal safety plan. However, if this tactic is used, the risk that the abuser could harm the animal in retaliation must be considered and carefully weighed.

Developmental disabilities. Violence is widespread in the romantic relationships of adults with developmental disabilities. Ward, Bosek, and Trimble (2010) found that 60% of individuals with developmental disabilities, who were or had ever been in a romantic relationship, indicated they have experienced interpersonal violence. Other studies corroborate these findings (e.g., Carlson, 1998). Individuals with developmental disabilities who reside in the community are vulnerable to abusers who may target them under the guise of "romantic relationships." Unfortunately, because people with developmental disabilities

are often excluded from sexuality education curricula and do not receive proper sociosexual skills training (Kim, 2010), they are not typically taught necessary skills to protect themselves against such victimization. Due to frequent contact with others responsible for assisting with activities of daily living, individuals with developmental disabilities are often encouraged to be trusting and compliant from a young age, which places them at further risk of victimization (Strickler, 2001), especially with intimate partners. Education on sexuality and interpersonal relationships, including accurate vocabulary to identify both physical aspects of one's body and emotions such as anger and fear, would serve as a good foundation for a self-protection curriculum (Mansell, Sobsey, & Calder, 1992). Khemka, Hickson, and Reynolds (2005) tested the effectiveness of an abuse prevention curriculum for women with intellectual disabilities and found that participants learned useful abuse prevention skills, including decision making, which could be applied in situations of intimate partner violence.

Literature on self-protection for people with disabilities is greatest in the area of developmental disabilities, although still scarce compared to literature available for the general population. Self-protection curricula for individuals with developmental disabilities must be understood by those with a range of cognitive abilities and learning styles and presented through the use of multisensory stimuli. This may include providing materials in various formats including pictures, manipulatives or videos, as well as simplifying language and providing positive reinforcement to encourage skill retention (Mazzucchelli, 2001). Including a nonabusive caregiver or friend in the learning/training process could be especially useful, since this individual could support and reinforce the use of newly acquired safety skills outside of the classroom or treatment session (Focht-New, Barol, Clements, & Milliken, 2008).

Psychiatric disabilities. There is a general stereotype that individuals with mental illness are violent, despite strong evidence to the contrary (Mastroleo & Schwartz, 2007). This misconception could hinder the legal defense of a woman with a psychiatric disability who is trying to protect herself from a partner's abuse. If she uses force against the abuser, for example, this stereotype may lead others to assume she is the aggressor due to her history of mental illness, further removing her from potential supporters who could assist her in escaping the abusive relationship. Service providers and criminal justice personnel must be informed in order to challenge the pervasive stereotypes that "blame the victim" when she is simply attempting to protect herself from an abusive partner.

In efforts to maintain power and control, abusive partners often seize upon any opportunity to decrease a woman's ability to react to an assault. One tactic to achieve this goal is overmedication, which will lead to slower reaction times and general sedation. In response, survivors may avoid all medication needed for chronic health issues including mental illness, out of fear that they will be unable to react quickly in a threatening situation (Lowe, Humphreys, & Williams, 2007). Correspondingly, a woman with a psychiatric disability may be obstructed from necessary medication or other treatment by an abuser who understands that an untreated mental health condition could lead to overwhelming psychological symptoms that render a woman unable to focus, think clearly, and protect herself from harm (Hoog, 2004).

Women with long histories of abuse may be easily "triggered" in a moment of danger, experiencing dissociation or flashbacks and making attempts at self-defense impossible (Hoog, 2004). Dissociation may also be a tactic developed by women with disabilities as a way to cope with uncomfortable medical procedures and a general lack of privacy in executing activities of daily living (Monahan & Lurie, 2003). As a result, when faced with a physical assault or threat from a partner, a survivor may be unable to react due to the triggered dissociation she is experiencing. Cognitive functioning is further negatively affected by psychological symptoms of psychiatric disability, manifested as decreased concentration, confusion, and forgetfulness, further preventing self-defense efforts (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008). Abusers may use this knowledge of their partner's triggered responses as an additional source of power against the woman.

Invisible disabilities. Not all disabilities are visually apparent. "Invisible" disabilities, such as traumatic brain injury, epilepsy, and other chronic illnesses, similarly affect strength, motor coordination, and reflexes, further compromising one's ability to react to physical threats (Hoog, 2004). Abuse itself may cause these invisible disabilities to emerge. Hassouneh-Phillips and McNeff (2005) found that the experience of abuse could trigger incapacitating secondary health conditions. Posttraumatic Stress Disorder, common among survivors of domestic violence, may worsen cognition among women with certain disabilities such as head injury, stroke, and multiple sclerosis (Beck-Massey, 1999). Traumatic brain injury is often a result of domestic violence, as frequent strikes to the head may occur along with other forms of abuse (Monahan & O'Leary, 1999). Head injuries impact safety skills planning and may impair judgment, further hindering self-protection efforts (Hoog, 2004). The ability to plan ahead and react quickly in anticipation of a physical assault is key to defending oneself, but invisible disabilities compromise these skills.

Case Example

The following example embodies the manner in which some barriers described in the previous section impact assessment and intervention. This example presents a client's initial work with a mental health practitioner specifically trained to counsel individuals with disabilities experiencing domestic violence. The case illustrates the multiple complex layers frequently relevant to the experiences of clients with disabilities. The following depiction highlights ways in which the intersection of disability, domestic violence, and self-protection skills can be explored to positively impact the course of treatment.

Kathy is a 30-year-old Caucasian woman with a spinal cord injury and bipolar disorder. Due to the spinal cord injury, Kathy uses a wheelchair. Her intimate partner, Mike, a 35-year-old Caucasian man, has been abusive toward Kathy for years, living with her for months, then disappearing for extended periods of time. He gains entry into Kathy's home by convincing her that he is in need of help and a place to stay, appealing to her sympathy and love for him. Kathy has expressed a belief that she can "do no better" than a man like Mike, as she has been bombarded with messages throughout her lifetime that she should never expect to marry or have an intimate relationship.

While living with Kathy, Mike exploits her financially. He is also emotionally, physically, and sexually abusive. He steals valuable items from her home, sells them, and then accuses her of being "crazy" and "inventing" the missing items. He perpetuates the myth that Kathy is damaged due to her disabilities, telling her that no other man would want to be with her and she is fortunate that he is willing "to lower himself" to be with her. If Kathy resists giving money or sex to Mike, he becomes physically abusive, slapping her head, kicking her legs, or pushing her wheelchair over. Mike has also denied Kathy access to the medication she uses to manage her bipolar disorder by hiding or destroying her pills. This exacerbates her risk for further abuse, as she is unable to respond as vigilantly to his abuse when her bipolar disorder is not properly managed.

Kathy believes she plays a role in the physical abuse stating that she occasionally upsets Mike by responding to his insults and slaps him if he hits her on the face. She acknowledges that her attempts to defend herself verbally and physically fail to deter Mike from harming her. Mike also provides Kathy with needed support in certain domestic areas such as cleaning. This presents a further challenge in regards to ending the relationship, as Kathy needs his assistance. She called a local domestic violence hotline for guidance regarding how to end the abuse and establish independence with the hope that her needs and wishes would be recognized and supported.

During the domestic violence hotline intake and assessment, a social work intern explored what self-defense tactics Kathy has used in the past, as this would provide insight into what actions have been successful and what has not worked previously. Asking Kathy, "Were you able to defend yourself in some way?" about each violent incident she describes, is essential. After realizing Kathy was not initially forthcoming with these behaviors, considering herself responsible for triggering the violence, the practitioner rephrased the question to help Kathy view her behaviors as self-protective, seeking to avert further harm (i.e., "Please tell me which actions you have used after Mike has hit you: (a) Hitting him with your hand or an object; (b) rolling over his feet with your wheelchair; (c) locking him out of the room you are in" etc.). Kathy's responses provided vital information about the safety skills she already possessed; these were then strengthened and expanded. For example, Kathy noted that distracting him with sexual advances sometimes provided adequate time for her to derail Mike's attacks, long enough to depart and hide in a locked room. Kathy strategically learned to vary the pattern of her behavioral and verbal responses as Mike tried to anticipate her actions based on prior movements. Ineffective tactics (e.g., throwing large heavy objects towards him in response to his blows) that escalated Mike's anger and resulted in self-injuries to her wrists were modified.

Service providers must be careful to avoid erroneously screening out clients like Kathy on the basis that she has previously physically lashed out at her partner. In Kathy's case, this was done strictly in self-defense. The self-defense strategies Kathy already used and the survival skills she had developed, including charging her backup wheelchair battery when Mike hid the one currently in use and wearing shin-guards under her pants to minimize the impact of his kicks, provide important assessment information. These narrative accounts contribute to a more accurate understanding of Kathy's strengths and vulnerabilities and mitigate the potential that a service provider will rely on stereotypes about mental health conditions and violence.

During intake, the social worker assessed Kathy's ability to execute basic activities of daily living and explored the societal barriers preventing her from acquiring a greater level of independence. Questions asked included, "Are community services so poor that you need to rely solely on Mike to provide you with the right level of personal assistance?" This yielded insight as to the role Mike played in her daily life and the other financial and social barriers she faced. In Kathy's case, Mike assisted her with occasional errands, cooking, and cleaning around the house, all things that were important to Kathy. These areas of assistance provided opportunities for exploitation and further abuse, as they became tools Mike leveraged to exert control over Kathy. Accordingly, Kathy's safety plan addressed the ways in which Mike took advantage of her disability and enhanced skills that lessened the need for his assistance. This included identifying alternative, trusted individuals like her sister and a paid caregiver, who could help with certain tasks, and providing Kathy with occupational therapy intended to heighten her ability to execute various tasks herself. Additionally, the practitioner provided Kathy with referrals for community agencies that assist with interviewing, hiring, and training personal care attendants to afford clients with needed services. It is incumbent upon professionals to encourage survivors with disabilities to discuss their experiences of barriers that deny them full societal participation and increase their risks for being in a relationship where domestic violence is common. Together, practitioners and clients should address individual and social change by highlighting capacities and personal resources that can be used to challenge barriers.

Kathy's responses to assessment questions highlighted her ability to detect Mike's pattern of escalated violence. Together, Kathy and the practitioner focused on self-protection skills that informed her individualized safety plan. Effective skills such as her ability to verbally diffuse Mike's anger when he was not using substances were noted and encouraged, while deficits were bolstered through a safety skills training component in the treatment plan. A key area in which Kathy sought support was her assertiveness skills. After long periods of time when Mike disappeared, Kathy would resolve not to let him back in her home, only to find herself providing him re-entry when he appealed to her kindness and sympathy. Kathy needed to believe that she truly had control over her life and had the right to refuse Mike's presence and accompanying abuse. Initially, Kathy did not see herself as a victim of violence because she considered her situation habitual and associated with her disability. The practitioner located a self-defense course for Kathy at a medical rehabilitation facility taught by a female instructor with a physical disability. Assertiveness training is a vital component of many self-defense programs. For Kathy, it was important that both verbal and physical methods of assertiveness were taught. By increasing Kathy's confidence in her capacity for independent personal safety and daily living, she was empowered to seek support in escaping Mike's abuse.

Considerations for Enhancing Self-Protection of Women With Disabilities

As illustrated in the case example, self-defense skills can be an integral component of intervention for domestic violence survivors with disabilities. Self-defense classes heighten self-confidence, reduce fear, and foster a positive self-image as well as feelings

of self-worth (Hollander, 2010). Survivors with disabilities would certainly benefit from this opportunity for empowerment, but self-defense resources are often not inclusive of those with a disability. Self-defense training programs for individuals with developmental disabilities do exist (Doughty & Kane, 2009; Kim, 2010; Mazzuchelli, 2001), but are not routinely available. Modifying physical aspects of courses to include women with mobility-related disabilities and thinking creatively about how women with physical disabilities may protect themselves is needed. For instance, as Kathy knew from her own experience, assistive devices such as wheelchairs and crutches can be used as defensive tools. A woman using a nonmotorized wheelchair may have a great deal of upper body strength because of the need to propel her chair; thus, a focus on physical strike techniques may be appropriate.

For women with sensory disabilities, trainings might include the use of canes to defend themselves (David et al., 1998), and accessibility in terms of communication is imperative including materials in Braille and the use of interpreters. Modification of materials conducive to various learning styles and teaching techniques are necessary for women with developmental disabilities. Assertiveness skills may have been discouraged for women with developmental disabilities; thus, self-defense courses may need to redress this socialization by focusing on concepts of personal space and the right to personal safety. For women with psychiatric disabilities, helping them identify their triggers and coping mechanisms will enhance their ability to react in a moment of danger (Hoog, 2004).

Prior to intervention, thoroughly assessing a woman's personal situation is necessary to determine an appropriate and effective treatment approach. When working with women with disabilities, a comprehensive assessment of ability and barriers to executing activities of daily living is advised. This assists the practitioner in providing client-focused services and reveals safety plan target areas, an essential component of self-protection (Cramer et al., 2003). For instance, a woman who is deaf may be able to use physical self-defense methods well, while for a female with a physical disability, tactics of verbal resistance may be more useful. Self-protection is not limited to physical self-defense methods, and women ideally ought to have a variety of skills, both physical and nonphysical, as this will give them greater range in responding to a variety of threatening situations.

Domestic violence psychosocial assessments often do not explore the survivor's use of force against the abuser. Rather, the focus is placed on the abuse perpetrated against the survivor. With this process, advocates may be missing important information about the survivor's self-defense methods, which are often a key survival skill developed in reaction to the abuse. Self-defense encompasses skills that extend beyond physical force alone. Hollomotz (2009) suggests that assertiveness and resistance skills, defined as having confidence in one's right to resist abuse, confidence, and ability to exercise control over the situation, enhance one's ability to self-protect. If these skills are lacking, then it is incumbent upon service providers to provide resources to develop them. Self-protective techniques must be adapted to each individual's ability level. For example, a woman who cannot speak may find that creating physical distance or holding up her hand to an abusive partner may be a good way to set self-protective relational boundaries. For others, yelling or other verbal warnings may be the best techniques.

Traditional safety plans often fail to take into account how disability might impact the execution of the plan (Erwin, 2000). There are the issues of depending on the abuser for assistance with daily needs, such as getting out of the house; maintaining contact with vital support services, such as doctors and psychiatrists once leaving an abusive situation; transferring needed assistive devices, such as hearing aids or service animals; and protecting confidentiality of shelters and safe spaces among individuals with developmental disabilities who may have difficulty understanding the concept (Hoog, 2001). One must also consider how an abuser might exploit aspects of a person's disability to his advantage, as this will figure into creating the safety plan. It should not be assumed that physical self-protection skills, such as the use of force, are not an option due to disability. Again, modifications are possible and should be used when safe and feasible.

Madorsky (1990) suggests three types of self-defense—preventive, psychological, and physical—can be taught to enhance self-protection skills among people with disabilities. Prevention may include taking steps to lessen exposure to harm at home, in public, and in social situations through comprehensive safety planning. Psychological defense can serve as an additional aspect of prevention through carefully considering one's options in a situation of potential harm or abuse and identifying personal resources and support systems. Finally, physical defense consists of strategies to either fight back or flee a dangerous situation. Weitlauf, Smith, and Cervone (2000) tested an intervention in which three levels of resistance to assault (physical, verbal, and emotional/psychological) were taught, and found that women not only felt more prepared to physically defend themselves in the event of an attack postintervention, but also felt greater control of their emotions during an attack and their abilities to discourage an assault. These are tactics that could serve a protective function in an intimate relationship, as the ability to think rationally and calmly during an attack gives a woman a greater opportunity to respond, if not physically then verbally.

A number of studies have detailed the empowerment effects and positive impact on sense of self-efficacy engendered by self-defense training, elements which are crucial to a woman who is experiencing domestic violence and considering her options (Brecklin, 2008; Hollander, 2010; McCaughey, 1997; Ozer & Bandura, 1990; Weitlauf, Cervone, Smith, & Wright, 2001; Weitlauf et al., 2000). Even if a woman never raises a hand to her abuser, the positive psychological effect of gaining self-defense skills could be the difference between remaining in an abusive relationship versus leaving. For instance, Hollander (2010) reports that women completing a comprehensive, feminist self-defense course reported increased confidence, reduced fear, more comfortable interactions with both acquaintances and intimate partners, more positive feelings about themselves and their bodies, and a general sense of self-worth. Improving self-esteem among women with disabilities is of utmost importance, as they tend to experience devaluation at the hands of both their abusers and society alike.

The power and control tactics imposed by an abusive intimate partner can be paralyzing, as violence is used as a tool to prevent the woman from fully participating in life. The isolation and constant denigration can leave one with a sense of feeling worthless, weak, and vulnerable. McCaughey (1997) makes note of the potentially transformative effect of learning self-defense, in which women begin to see themselves as "worth fighting for"

(p. 9). This is not necessarily in reference to physical fighting as the example is given of a woman who, after practicing how to yell "No!" in a self-defense class, commented, "That's the first time I've ever said 'no'"" (McCaughey, 1997, p. 9). Yelling at an assailant in a confident and threatening manner can be as effective a deterrent as physical defense methods and, in some cases, may be a safer tactic. While physical defense methods may not always be possible for all women with disabilities, many can certainly be taught to use their voices as a weapon. Learning to say "no" may be the first step in such an intervention, as many women with disabilities have been socialized to acquiesce to others' needs from an early age (Monahan & Lurie, 2003).

Many domestic violence agencies screen to ensure that those seeking services are not abusive themselves. However, in this process, a distinction needs to be made between force used as self-defense versus other types of aggression. Responding affirmatively to a question such as "Have you ever physically harmed another person?" may lead to a survivor being labeled as an abuser. With more careful exploration, though, it may be revealed that the survivor has used physical force simply as means to protect herself or ward off attacks. Additionally, aggressive behaviors may be exacerbated by certain medications or be a symptom of some disabilities such as head injuries (Monahan & O'Leary, 1999). In this case, women with disabilities may be viewed as hostile or violent when exhibiting normal symptoms related to their disability such as irritability and agitation. Domestic violence agencies and shelters should examine policies surrounding individual histories of "aggressive" behaviors and ensure that women are not being excluded from services due to a history of physical force used for the purpose of self-defense.

In the same vein, the possibility that a woman acting in self-defense could be portrayed by the abuser as a baseless attacker, and the possibility that women who do not use self-defense in the course of an attack will be blamed by others, and/or blame themselves, are topics to be addressed with survivors. It is not uncommon for testimony from a woman with a disability to be discredited due to myths and stereotypes about her motives and intellectual capacities (Mitchell & Buchele-Ash, 2000). Police may assume that women with mental illnesses or learning disabilities are more often offenders rather than victims (Sin, Mguni, Cook, Comber, & Hedges, 2009), and support these claims when used by the perpetrator, especially when he is nondisabled. Perpetrators may explain away injuries sustained by victims as a direct result of the disability. For example, a perpetrator may claim that bruises on a woman who uses a wheelchair are due to continuous falls as opposed to abuse. Survivors with disabilities may experience more medical issues than those without disabilities, such as pelvic pain, headaches, and back problems, leading physicians, advocates, and police to erroneously conclude that physical ailments are due to the disability and not abuse (Nosek, Howland, & Hughes, 2001). Knowingly, perpetrators may be effective in denying claims that injuries are due to abuse, thus discrediting a woman's justification of self-defense in response to physical harm.

When women with disabilities do use self-defense, the social expectation that women with disabilities are weak and vulnerable may result in greater punishment for their actions. Miller (2001) observed that women who step outside of traditional gender expectations, as they do when they retaliate physically against violence, are more often regarded as the

perpetrator rather than the victim. This could be compounded for women with disabilities, who are more often expected to be quiet and agreeable. Dasgupta (2002) notes the rise in arrests of women since the enactment of mandatory arrest policies, which were originally intended as a way to protect victims. Perversely, these policies have been used against victims in cases in which they used self-defense. Perpetrators may be more likely to call the police to report violence committed by their partners, even if it was in self-defense, knowing that mandatory arrest policies require the woman as well as the man to be arrested, if both were injured (Miller, 2001). Experienced perpetrators may have intimate knowledge of mandatory arrest policies due to frequent contact with the criminal justice system. They may use legal knowledge to their advantage by self-inflicting wounds, calling the police first in order to maintain control of the situation, and appearing calm when the police arrive, in stark contrast to the often visibly shaken victim (Miller, 2001).

Furthermore, self-defense may only be considered justifiable in cases in which a woman's "bodily integrity" (Dasgupta, 2002, p. 1372) is threatened, failing to acknowledge the extreme fear batterers can engender simply by using menacing words, gestures, or looks. Abuse against women with disabilities is often subtle and nuanced, and may not be physically violent, but is no less damaging. In what case, then, would it be considered justifiable for a woman with a disability to use self-defense against her partner? What if an abuser were to threaten a woman's service animal, for example? Her physical retaliation in this case would not likely be viewed as self-defense, and she could be criminally punished as a result.

When presenting self-protection options to survivors of domestic violence, it must be made clear that while these tactics may be useful in a moment of danger, a survivor cannot be expected to use these tactics, or blamed if she does not. Survivors with disabilities face additional barriers in either trying to defend themselves against abuse or leaving an abusive relationship, which have been detailed in this article. However, factors beyond the often unbalanced power dynamic between survivors with disabilities and their abusers must be acknowledged. Buel (1999) details a number of reasons why survivors do not leave abusive relationships, including fear of retaliation by the abuser; the decision that it is safer to stay, since the victim can more easily determine the whereabouts of the abuser in this instance; feelings of love for the abuser; a desire to keep one's family together; hope that the violence will stop; and a sense of shame and embarrassment, among other reasons.

These issues can serve to deter self-defense methods against one's partner, particularly if there is a possibility of physically harming the individual in the process. For instance, if a woman fights back, will this enrage the abuser and prompt more severe retaliation? If a woman has children with the abuser, what will the emotional impact of their mother physically harming their father be? How will the woman react if she does seriously injure her partner for whom she may have feelings of love, even if she was reacting in self-defense? These sensitive issues must be acknowledged in any self-defense training. Therefore, Madden and Sokol (1997) recommend taking time throughout self-defense training to explore the emotional impact of using such skills.

A final self-defense education point should be attended to, that is, the possibility that a victim may find herself immobilized in a moment of intense fear or danger. The inability

to react in such a situation is, in fact, a natural response to threat, sometimes referred to in the triad of "fight, flight, or freeze" (Macy, Barry, & Noam, 2003, p.16). In this case, a victim may fight back, flee the situation, or find herself unable to move, effectively "freezing" in the situation in order to survive. There are times when a victim may have no choice but to endure an assault and will not have a choice to fight or flee, either because it is simply too dangerous or because the victim is overpowered. Even if a woman is trained in self-defense methods, there may be times when it is simply not possible to use the self-defense methods. This is a crucial self-defense training point, as women with disabilities may blame themselves if they are unable to defend against an attack.

While worthy of serious consideration, these concerns should not preclude women from accessing self-defense education as one tactic among many to employ in the struggle against domestic violence. A victim who decides to call the police, take an abuser to court, or leave to stay in a shelter faces similar dangers. Safety plans must be specific to each victim, taking into account the complexity of her life, but the decision of whether or not to use self-defense must be her own. To deprive women with disabilities of the tools to make this decision, however, is not the answer. Madden and Sokol (1997) liken this to restraining order use in deterring perpetrator violence, noting that while restraining orders do not unequivocally stop perpetrators from offending again, they can serve as one promising violence prevention tactic.

Women with disabilities may be taught to channel use-of-force as a means of self-defense more constructively. But this should be done through discussions between service providers and survivors. Pervasive myths and stereotypes about women with disabilities, such as their being asexual or undesirable as intimate partners (Brownridge, 2009), continue to exclude women from sexual violence survivorship conversations. Women with disabilities are diverse in experiences, needs, strengths, and expertise. Professional intervention must respect this diversity. The voices of women with disabilities, and an appreciation of the survival skills they already employ in their daily lives, must be included in future disability-sensitive self-defense curricula. Women with disabilities ought to be included in any research conducted on their behalf, either as coresearchers or consultants, in order to ensure that the research undertaken is accurate and does not further perpetuate stereotypes and myths regarding disability (Lightfoot & Williams, 2009).

Recruiting women with disabilities for self-defense classes by placing announcements in local newspapers, radio, television, doctors' offices, social service agencies and clinics, and community recreation centers may increase their class attendance, and ensure their future inclusion in needs assessment (Nosek, Howland, & Hughes, 2001). Copel (2006) found that women with disabilities connected with information and resources regarding abuse are more likely to leave the abusive situation. Brownridge (2006) also underscores the importance of providing resources to survivors of domestic violence with disabilities, noting that the greater knowledge and resource access a woman with disabilities has relative to her partner, the more power she would have in the relationship. Power begins with education, and a woman deprived of a range of options and resources will be especially challenged to establish independence from an abusive partner.

The provision of self-defense classes specifically attending to intimate partner violence, as opposed to prevention of violence in general, would likely enhance such education. Currently, most self-defense classes do not identify the offender targeted. The literature on self-defense tends to make a broad reference to "rape prevention" and "self-defense skills," without a clear explanation of exactly whom these skills are meant to repel. In Brecklin's (2008) review of 20 quantitative studies assessing the impact of self-defense training on female participants, the classes described focused on rape avoidance, and while it has been established that rape is a tactic commonly used by intimate partners (Ullman, 2007), it was not specified whether or not the skills taught in these classes were intended to be used against intimate partners or strangers. Hollander (2009) likewise reviewed the extant literature on women's resistance to violence and found that most studies focused on the effectiveness of self-protection when avoiding sexual assault by strangers or acquaintances and not intimate partners.

While the skills learned in self-defense classes may provide benefits to women involved in intimate relationships, classes tend not to explicitly address this, and present scenarios more reminiscent of stranger assaults. Classes should specifically attend to intimate relationship dynamics. For instance, how does a woman respond to violence when she must continue to live with that person? Incorporating the physical emotional and psychological components may correct this, along with a frank discussion of the risks.

Feeling strong and in control of one's body is a necessary aspect of empowerment, which in turn is often the first step in the long process of escaping an abusive situation. Women with disabilities express a desire for greater access to physical fitness activities, but struggle to find information on what activities would benefit them (Nosek, Howland, Rintala et al., 2001). Research on how women with disabilities can adapt self-defense techniques is necessary for personal empowerment. Otherwise, women with disabilities may believe that defending themselves simply is not an option, further eroding any sense of control or self-efficacy.

It has been widely noted that more research regarding specific interventions for domestic violence survivors with disabilities is sorely needed (Curry et al., 2001; Hassouneh-Philips & McNeff, 2005; Lightfoot & Williams, 2009; Nosek & Howland, 1998; Nosek, Howland, & Hughes, 2001). Current domestic violence interventions range from crisis responses to abuse (including connections to shelter, police, and emergency financial assistance), promoting safety skills, connection to information and resources, and long-term individual and group counseling to help women cope with the experience of abuse. Further research examining the experiences of women with disabilities would allow for targeted services development, policies, and interventions (Gilson et al., 2001; Smith, 2008). Self-defense training is one empowering woman-focused intervention, but remains highly controversial (Hollander, 2009; McCaughey, 1997). This is due, in part, to the limited research, yet it is also likely that societal expectations for females contribute to a negative view of self-defense for women. Women are expected to be feminine, quiet, and polite; they are not expected to be assertive, to yell, scream, kick, or punch (McCaughey, 1997). For women with disabilities, this expectation may be further ingrained in the social consciousness.

Connecting women to disability-sensitive services including self-defense curricula is a crucial first step in ending the unacceptably high levels of domestic violence against women with disabilities. Indeed, we cannot lose sight of the need to change social conditions and perceptions of "disability," and the role such changes will play in promoting the safety of women with disabilities (Brownridge, 2009). The most efficacious prevention of violence against women with disabilities will rely on changing societal attitudes that dehumanize women with disabilities (Copel, 2006).

Conclusion

Domestic violence survivors with disabilities are themselves the experts on which strategies are the most successful in their relationships and under what circumstances. Future research that examines self-protective strategies women with disabilities employ will help other women and may also motivate abusive partners to reduce violence against them over time. Ending intimate partner violence should not be viewed as the responsibility of women with disabilities who need to be educated and empowered to become skilled at self-defense. Although such training is important, domestic violence is not the result of a woman's "vulnerability" to abuse or inability to defend against it. Male intimate partners who violate women's bodily integrity and who facilitate conditions for abuse and power cause domestic violence. Removing conditions that create risk is the responsibility of our society, more specifically the systems that aim to provide equal protection for all.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

References

Bachman, R., & Carmody, D. C. (1994). Fighting fire with fire: The effects of victim resistance in intimate versus stranger perpetrated assaults against females. *Journal of Family Violence*, *9*, 317-331.

Bachman, R., Lachs, M., & Meloy, M. (2004). Reducing injury through self-protection by elderly victims of violence: The interaction effects of gender of victim and the victim/offender relationship. *Journal of Elder Abuse & Neglect*, *16*, 1-24.

Barranti, C. C. R., & Yuen, K. O. (2008). Intimate partner violence and women with disabilities: Toward bringing visibility to an unrecognized population. *Journal of Social Work in Disability & Rehabilitation*, *7*, 115-130.

Barrett, K. A., O'Day, B., Roche, A., & Carlson, B. L. (2009). Intimate partner violence, health status and health care access among women with disabilities. *Women's Health Issues*, *19*, 94-100.

Beck-Massey, D. (1999). Sanctioned war: Women, violence, and disabilities. *Sexuality and Disability*, *17*, 269-276.

Brecklin, L. R. (2008). Evaluation of outcomes of self-defense training for women: A review. *Aggression and Violent Behavior*, *13*, 60-76.

Brodwin, M. G., & Siu, F. W. (2007). Domestic violence against women who have disabilities: What educators need to know. *Education*, *127*, 548-551.

Brownridge, D. A. (2006). Partner violence against women with disabilities: Prevalence, risk, and explanations. *Violence Against Women*, *12*, 805-822.

Brownridge, D. A. (2009). *Violence against women: Vulnerable populations*. New York: Routledge.

Brownridge, D. A., Ristock, J., & Heibert-Murphy, D. (2008). The high risk of IPV against Canadian women with disabilities. *Medical Science Monitor*, *14*, PH27-PH32.

Buel, S. M. (1999). Fifty obstacles to leaving, a.k.a., why abuse victims stay. *Colorado Lawyer*, *28*, 19-28.

Carlson, B. E. (1998). Domestic violence in adults with mental retardation: Reports from victims and key informants. *Mental Health Aspects of Developmental Disabilities*, *1*, 102-112.

Casteel, C., Martin, S. L., Smith, J. B., Gurka, K. K., & Kupper, L. L. (2008). National study of physical and sexual assault among women with disabilities. *Injury Prevention*, *14*, 87-90.

Chang, J. C., Martin, S. L., Moracco, K. E., Dulli, L., Scandlin, D., & Loucks-Sorrel, M. B. et al. (2003). Helping women with disabilities and domestic violence: Strategies, limitations, and challenges of domestic violence programs and services. *Journal of Women's Health*, *12*, 699-708.

Chenoweth, L. (1996). Violence and women with disabilities. *Violence Against Women*, *2*, 391-411.

Clay-Warner, J. (2002). Avoiding rape: The effect of protective actions and situational factors on rape outcome. *Violence and Victims*, *17*, 691-705.

Cohen, M. A., Forte, T., Du Mont, J., Hyman, I., & Romans, S. (2005). Intimate partner violence among Canadian women with activity limitations. *Journal of Epidemiology & Community, Health*, *59*, 834-839.

Coker, A. L., Smith, P. H., & Fadden, M. K. (2005). Intimate partner violence and disabilities among women attending family practice clinics. *Journal of Women's Health*, *14*, 829-838.

Copel, L. C. (2006). Partner abuse in physically disabled women: A proposed model for understanding intimate partner violence. *Perspectives in Psychiatric Care*, *42*, 114-130.

Cramer, E. P., Gilson, S. F., & DePoy, E. (2003). Women with disabilities and experiences of abuse. *Journal of Human Behavior in the Social Environment*, *7*, 183-199.

Curry, M. A., Hassouneh-Phillips, D., & Johnston-Silverberg, A. (2001). Abuse of women with disabilities: An ecological model and review. *Violence Against Women*, *7*, 60-79.

Dasgupta, S. D. (2002). A framework for understanding women's use of nonlethal violence in intimate heterosexual relationships. *Violence Against Women*, *8*, 1364-1389.

David, W., Kollmar, K., & McCall, S. (1998). *Safe without sight: Crime prevention and self-defense strategies for people who are blind*. Boston, MA: National Braille Press.

Doughty, A. H., & Kane, L. M. (2009). Teaching abuse-protection skills to people with intellectual disabilities: A review of the literature. *Research in Developmental Disabilities*, *31*, 331-337.

Downs, W. R., Rindels, B., & Atkinson, C. (2007). Women's use of physical and nonphysical self-defense strategies during incidents of partner violence. *Violence Against Women*, *13*, 28-45.

Dutton, M. A. (1992). *Empowering and healing the battered woman*. New York: Springer.

Erwin, P. E. (2000). *Intimate and caregiver violence against women with disabilities*. Minneapolis, MN: Battered Women's Justice Project, Criminal Justice Office.

Feuerstein, P. B. (1997). *Domestic violence and women and children with disabilities*. New York: Milbank Memorial Fund.

Focht-New, G., Barol, B., Clements, P. T., & Milliken, T. F. (2008). Persons with developmental disability exposed to interpersonal violence and crime: Approaches for intervention. *Perspectives in Psychiatric Care*, *44*, 89-98.

Gilson, S. F., Cramer, E. P., & Depoy, E. (2001). Redefining abuse of women with disabilities: A paradox of limitation and expansion. *Affilia*, *16*, 220-235.

Grande, E. D., Hickling, J., Taylor, A., & Woollacott, T. (2003). Domestic violence in South Australia: A population survey of males and females. *Australian and New Zealand Journal of Public Health*, *27*, 543-550.

Hamberger, L. K., & Guse, C. E. (2002). Men's and women's use of intimate partner violence in clinical samples. *Violence Against Women*, *8*, 1301-1331.

Hassouneh-Philips, D., & Curry, M. A. (2002). Abuse of women with disabilities: State of the science. *Rehabilitation Counseling Bulletin*, *45*, 96-104.

Hassouneh-Philips, D., & McNeff, E. (2005). "I thought I was less worthy": Low sexual and body esteem and increased vulnerability to intimate partner abuse in women with physical disabilities. *Sexuality and Disability*, *23*, 227-240.

Hassouneh-Philips, D., McNeff, E., Powers, L., & Curry, M. A. (2005). Invalidation: A central process underlying maltreatment of women with disabilities. *Women & Health*, *41*, 33-50.

Helfrich, C. A., Fujiura, G. T., & Rutkowski-Kmitta, V. (2008). Mental health disorders and functioning of women in domestic violence shelters. *Journal of Interpersonal Violence*, *23*, 437-453.

Hollander, J. A. (2004). "I can take care of myself": The impact of self-defense training on women's lives. *Violence Against Women*, *10*, 205-235.

Hollander, J. A. (2009). The roots of resistance to women's self-defense. *Violence Against Women*, *15*, 574-594.

Hollander, J. A. (2010). Why do women take self-defense courses? *Violence Against Women*, *16*, 459-478.

Hollomotz, A. (2009). Beyond "vulnerability": An ecological model approach to conceptualizing risk of sexual violence against people with learning difficulties. *British Journal of Social Work*, *39*, 99-112.

Hoog, C. (2001). *Enough and yet not enough: An educational resource manual on domestic violence advocacy for persons with disabilities in Washington state*. Seattle, WA: Washington State Coalition Against Domestic Violence.

Hoog, C. (2004). *Model protocol on safety planning for domestic violence victims with disabilities*. Seattle, WA: Washington State Coalition Against Domestic Violence.

International Network of Women with Disabilities. (2010). *Document on violence against women with disabilities*. Retrieved from http://groups.yahoo.com/group/inwwd

Khemka, I., Hickson, L., & Reynolds, G. (2005). Evaluation of a decision-making curriculum designed to empower women with mental retardation to resist abuse. *American Journal on Mental Retardation*, *110*, 193-204.

Kim, Y. R. (2010). Personal safety programs for children with intellectual disabilities. *Education and Training in Autism and Developmental Disabilities*, *45*, 312-319.

Lightfoot, E., & Williams, O. (2009). Critical issues in researching domestic violence among people of color with disabilities. *Journal of Aggression, Maltreatment, & Trauma*, *18*, 200-219.

Lowe, P., Humphreys, C., & Williams, S. J. (2007). Night terrors: Women's experiences of (not) sleeping where there is domestic violence. *Violence Against Women*, *13*, 549-561.

Macy, R. D., Barry, S., & Norm, G. G. (2003). Threat and trauma: An overview. *New Directions for Youth Development*, *98*, 11-28.

Madden, M. E., & Sokol, J. S. (1997). Teaching women self-defense: Pedagogical issues. *Feminist Teacher*, *11*, 133-151.

Madorsky, J. G. (1990). Self-defense for people with disabilities. *Western Journal of Medicine*, *153*, 434-435.

Magowan, P. (2003). Nowhere to run, nowhere to hide: Domestic violence and disabled women. *Safe: Domestic Abuse Quarterly*, *5*, 15-18.

Mansell, S., Sobsey, D., & Calder, P. (1992). Sexual abuse treatment for persons with developmental disabilities. *Professional Psychology: Research and Practice*, *23*, 404-409.

Marchbanks, P. A., Lui, K. J., & Mercy, J. A. (1990). Risk of injury from resisting rape. *American Journal of Epidemiology*, *132*, 540-549.

Martin, S. L., Ray, N., Sotres-Alvarez, D., Kupper, L. L., Moracco, K. E., & Dickens, P. A. et al. (2006). Physical and sexual assault of women with disabilities. *Violence Against Women*, *12*, 823-837.

Mastroleo, C., & Schwartz, M. (2007). *Disability services ASAP: Ensuring accessible services to crime victims with mental illness*. Austin, TX: Safeplace.

Mays, J. (2006). Feminist disability theory: Domestic violence against women with a disability. *Disability & Society*, *21*, 147-158.

Mazzucchelli, T. G. (2001). Feel safe: A pilot study of a protective behaviours programme for people with intellectual disability. *Journal of Intellectual & Developmental Disability*, *26*, 115-126.

McCaughey, M. (1997). *Real knockouts: The physical feminism of women's self-defense*. New York: New York University Press.

Milberger, S., Israel, N., LeRoy, B., Marin, A., Potter, L., & Patchak-Schuster, P. (2003). Violence against women with physical disabilities. *Violence and Victims*, *18*, 581-591.

Miller, S. L. (2001). The paradox of women arrested for domestic violence: Criminal justice professionals and service providers respond. *Violence Against Women*, *7*, 1339-1376.

Mitchell, L. M., & Buchele-Ash, L. (2000). Abuse and neglect of individuals with disabilities: Building protective supports through public policy. *Journal of Disability Policy Studies*, *10*, 225-243.

Monahan, K., & Lurie, A. (2003). Disabled women sexually abused in childhood: Treatment considerations. *Clinical Social Work Journal*, *31*, 407-418.

Monahan, K., & O'Leary, K. D. (1999). Head injury and battered women: An initial inquiry. *Health & Social Work*, *24*, 269-278.

Nixon, J. (2009). Domestic violence and women with disabilities: Locating the issue on the periphery of social movements. *Disability & Society*, *24*, 77-89.

Nosek, M. A., Clubb-Foley, C., Hughes, R. B., & Howland, R. B. (2001). Vulnerabilities for abuse among women with disabilities. *Sexuality and Disability*, *19*, 177-189.

Nosek, M. A., & Howland, C. A. (1998). Abuse and women with disabilities. *National Electronic Network on Violence Against Women*. Retrieved from www.vawnet.org/domesticviolence/research/VAWnetDocs/AR-disab.pdf

Nosek, M. A., Howland, C. A., & Hughes, R. B. (2001). The investigation of abuse and women with disabilities: Going beyond assumptions. *Violence Against Women*, *7*, 477-499.

Nosek, M. A., Howland, C. A., Rintala, D. H., Young, M. E., & Chanpong, G. F. (2001). National study of women with physical disabilities: Final report. *Sexuality and Disability*, *19*, 5-39.

Nosek, M. A., Hughes, R. B., Taylor, H. B., & Taylor, P. (2006). Disability, psychosocial, and demographic characteristics of abused women with physical disabilities. *Violence Against Women*, *12*, 838-850.

Ozer, E. M., & Bandura, A. (1990). Mechanisms governing empowerment effects: A self-efficacy analysis. *Journal of Personality and Social Psychology*, *58*, 472-486.

Pava, W. S. (1994). Visually impaired persons' vulnerability to sexual and physical assault. *Journal of Visual Impairment & Blindness*, *88*, 103-112.

Petersilia, J. (2000). Invisible victims: Violence against persons with developmental disabilities. *Human Rights*, *27*, 9-12.

Powers, L. E., Renker, P., Robinson-Whelen, S., Oschwald, M., Hughes, R., Swank, P., & Curry, M. A. (2009). Interpersonal violence and women with disabilities: Analysis of safety promoting behaviors. *Violence Against Women*, *15*, 1040-1069.

Radford, J., Harne, L., & Trotter, J. (2006). Disabled women and domestic violence as violent crime. *Practice*, *18*, 233-246.

Ruback, R. B., & Ivie, D. L. (1988). Prior relationship, resistance, and injury in rapes: An analysis of crisis center records. *Violence and Victims*, *3*, 99-111.

Saxton, M., Curry, M. A., Powers, L. E., Maley, S., Eckels, K, & Gross, J. (2001). "Bring my scooter so I can leave you": A study of disabled women handling abuse by personal assistance providers. *Violence Against Women*, *7*, 393-417.

Sin, C. H., Mguni, N., Cook, C., Comber, N., & Hedges, A. (2009). Disabled victims of targeted violence, harassment, and abuse: Barriers to reporting and seeking redress. *Safer Communities*, *8*, 27-34.

Smith, D. L. (2008). Disability, gender, and intimate partner violence: Relationships from the Behavioral Risk Factor Surveillance System. *Sexuality & Disability*, *26*, 15-28.

Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities*. Baltimore, MD: Paul H. Brookes.

Strickler, H. (2001). Interaction between family violence and mental retardation. *Mental Retardation*, *39*, 461-471.

Swan, S. C., Gambone, L. T., Caldwell, J. E., Sullivan, T. P., & Snow, D. L. (2008). A review of research on women's use of violence with male intimate partners. *Violence and Victims*, *23*, 301-314.

Swan, S. C., & Snow, D. L. (2002). A typology of women's use of violence in intimate relationships. *Violence Against Women*, *8*, 286-319.

Swedlund, N. P., & Nosek, M. A. (2000). An exploratory study on the work of independent living centers to address abuse of women with disabilities. *Journal of Rehabilitation*, *66*, 57-64.

Taylor, L. R., & Gaskin-Laniyan, N. (2007). Study reveals unique issues faced by deaf victims of sexual assault. *National Institute of Justice Journal*, *257*, 24-26.

Thompson, M. P., Simon, T. R., Saltzman, L. E., & Mercy, J. A. (1999). Epidemiology of injuries among women after physical assaults: The role of self-protective behaviors. *American Journal of Epidemiology*, *150*, 235-244.

Ullman, S. E. (2007). A 10-year update of "Review and critique of empirical studies of rape avoidance." *Criminal Justice and Behavior*, *34*, 411-429.

Uno, H., Ui, S., & Aoyama, A. (2004). Domestic violence: Public health perspectives. *Japanese Journal of Public Health*, *51*, 305-310.

Ward, K. M., Bosek, R. L., & Trimble, E. (2010). Romantic relationships and interpersonal violence among adults with developmental disabilities. *Intellectual and Developmental Disabilities*, *48*, 89-98.

Weitlauf, J. C., Cervone, D., Smith, R. E., & Wright, P. M. (2001). Assessing generalization in perceived self-efficacy: Multidomain and global assessments of the effects of self-defense training for women. *Personality & Social Psychology Bulletin*, *27*, 1683-1691.

Weitlauf, J. C., Smith, R. E., & Cervone, D. (2000). Generalization effects of coping skills training: Influence of self-defense training on women's efficacy beliefs, assertiveness, and aggression. *Journal of Applied Psychology*, *85*, 625-633.

Wisseman, K. B. (2000). "You're my pretty bird in a cage": Disability, domestic violence, and survival. In W. H. Abramson, E. J. Emanuel, & M. Hayden (Eds.), *Impact: Feature issue on violence against women with developmental or other disabilities*, 13. Minneapolis, MN: University of Minnesota, Institute on Community Integration.

Bios

Michelle S. Ballan is an assistant professor at Columbia University School of Social Work. She has over 10 years of experience in the implementation and evaluation of direct practice interventions with individuals with disabilities and their families. She has authored more than 20 academic papers and a book and lectured extensively at national and international conferences. She was the recipient of three prestigious awards in 2010-2011: The Columbia University Presidential Teaching Award, the Association on Higher Education and Disability Recognition Award, and the Early Career Award from the American Association on Intellectual and Developmental Disabilities. She has worked as a practitioner at the New Jersey Brain Injury Association, Women Helping Women, and Safeplace.

Molly Burke Freyer received her MSW from Columbia University and is pursuing a PhD in social work at New York University. Her work with survivors of domestic violence with disabilities commenced during her internship at the King County District Attorney's Office. Upon graduation with her MSW, she served as the assistant director of Barrier Free Living's Nonresidential Domestic Violence Program, a domestic violence agency serving individuals with disabilities. She is currently the project director on a retrospective case study of the demographics of 1,000 clients of a domestic violence program for individuals with disabilities.