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Intimate Partner Violence Against Disabled Women as a Part of Widespread Victimization and Discrimination over the Lifetime: Evidence from a German Representative Study

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Prevalence rates of partner violence are high for women in general, but disabled women seem to be even more vulnerable. To explore this question, interviews were conducted with a representative sample of women with physical, mental, intellectual, hearing, and vision disabilities living in households (N=800) and in institutions (N=420). Additionally, a supplementary survey with a non-representative sample of blind, severely physically/multiply disabled, and deaf women (N=341) and qualitative interviews with thirty-one victimized women with disabilities were conducted. The standardized questionnaire was comparable to an earlier German representative survey on violence against women in the general population (N=10,264). Overall, 25 to 45 percent of women with disabilities had experienced intimate partner violence, which is two to five times the rate for the general population (depending on the specific group). Type and severity of disability, living situation, and experience of discrimination and violence in childhood and adolescence correlated with increased vulnerability. The findings confirm the hypothesis of elevated vulnerability discussed in international research and deepen insights into risk factors for victimization, for example discrimination, violence in childhood and youth, life situation, and type of disability. The results are crucial for further research as well as for prevention, intervention and support.

After having been invisible for many decades, violence against women is an increasingly studied phenomenon. Different studies show that the most common perpetrators of violence against women are current and former intimate partners. Large-scale prevalence surveys conducted in many countries over the past two decades found prevalence rates of at least 15–36 percent for physical and/or sexual partner violence against women in many countries across Europe, as well as in the United States, Canada and Australia (Black et al. 2011; Collins et al. 1999; Schröttle et al. 2006; Tjaden and Thoennes 2000; WAVE 2012). International surveys found even higher rates in African, South Asian and Latin American countries (WHO 2005; International Violence against Women Survey, see Johnson, Ollus, and Nevala 2008).

Research has revealed several risk factors that elevate the prevalence of intimate partner violence, such as the experience of sexual, physical, or emotional child abuse, witnessing violence against the mother as a child, alcohol abuse, pregnancy, separation, ethnicity, and power imbalance between the partners (Abramsky et al. 2011; Johnson, Ollus, and Nevala 2008; Schröttle and Ansorge 2009; Schröttle et al. 2006; Stith et al. 2004). Another important but rarely discussed risk factor is disability. In the past decade, research on violence against women with disabilities has found indications of highly increased prevalence rates compared to women without disabilities (see e.g. Brownridge 2006; Foster and Sandel 2010; Hall and Innes 2010; Marge 2003; Nosek, Howland et al. 2001; Powers, Hughes, and Lund 2009; Smith 2008; Schröttle et al. 2013, Schröttle et al. forthcoming).[1] Women with disabilities seem to be more likely to experience violence and are affected by more severe violence (Brownridge 2006) over a longer period of time (Nosek, Howland, and Hughes 2001). Some small-

1 The terms "women with disabilities" and "disabled women" are used interchangeably, recognising that there are different ideas about their political implications. The term "disabled people" and "disability" in the singular, which is preferred in the United Kingdom, can be used to describe "the impacts of a discriminating society, rather than as a word to refer to the individual conditions or impairments that people may have" (Thiara et al. 2012,

scale and a few large-scale studies are available, but the research is still thin.[2]

Small studies are often unrepresentative and/or unable to compare data from different groups of women with and without disabilities. Most of the available large-scale data on violence against disabled women is based on unrepresentative samples as it usually excludes women living in institutions, deaf women, and women with intellectual disabilities. Studies that interview disabled women in a sensitive and low-threshold or barrier-free way and are able to unfold the broader life situation and the continuum of several types of violence and discrimination through the life time are rare, as are studies that produce comparable data for women with intellectual disabilities using simple language or for deaf women using sign language.

To fill some of these gaps, the Interdisciplinary Center for Women and Gender Studies at the University of Bielefeld conducted a German nationally representative study on violence against women with various disabilities in different living situations (see Schröttle et al. 2012 and Schröttle et al. forthcoming for a summary of the results and Schröttle et al. 2013 for the full report). An additional qualitative study with thirty-one victimized women with disabilities was conducted within the project to explore in greater depth the disabled women's experiences of violence and help-seeking behaviour.

The aim was to explore the experiences of women with disabilities in comparison to women without disabilities: To what extent can similarities and/or differences be found, for example, in terms of prevalence and forms of violence? Are there certain groups of disabled women who are even more vulnerable than others? What role does the type of disability play? How do the living situation (private household or institution) and biographical experiences affect vulnerability for intimate partner violence? Which factors increase the risk of experiencing violence in the context of disability?

After describing the theoretical background, the methods and empirical findings of the study are presented and discussed with reference to the relevant literature. The paper focuses on prevalence, risk factors, and vulnerabilities in the context of violence dynamics, gender, and disability constructions. It must be stressed that intimate partner violence against disabled women is embedded in other relevant forms and contexts of violence and discrimination that have to be taken into account for a full understanding of the problem.

1. Theoretical Background

Although women with disabilities are "collectively defined as a social monolith" (Foster and Sandel 2012, 180), the differences among disabled women are substantial, and they experience the phenomenon of disability differently. On the one hand, their experience depends on "the type and severity of disability, the age and manner of disability onset" (ibid.), socioeconomic and demographic characteristics, and biographical experiences. On the other hand, Foster and Sandel (2012) identify the social and institutional categorization "disabled" and the associated discrimination as a shared thread (ibid.). Social norms contribute to the stigmatization of women with disabilities as undervalued, undesirable, asexual, naïve, and dependent, and give thus rise to abuse (ibid., 181). The greater vulnerability of disabled women can be understood in an intersectional perspective as simultaneous discrimination relating to disability and gender (Brownridge 2006; Chenoweth 1996; Köbsell 2010).

Gender studies have shown that gender is a social, symbolic, and cultural construction (Becker and Kortendiek 2010; Davis, Evans, and Lorber 2006; Hagemann-White1988; Lorber 1994). Constructing women in contrast

14). In other countries, such as the United States, Canada, Australia, and certain European countries, "people first" language is used to "emphasize the critical importance of understanding that people happen to experience disabilities that do not define them" (Powers, Hughes, and Lund 2009, 1). In Germany the politically preferred wording is not undisputed: there are groups preferring the one or the other term, both for good reasons as explained above.

2 For an overview see the latest systematic review and meta-analysis of observational studies by Hughes et al. (2012).

to men as weak, passive, dependent, and in need of (male) help is still an influential social process. In the process of socialization, women establish subject positions between self-determination, autonomy, and heteronomy. Potential and experienced violence plays an important role, because it occurs on the basis of the construction of male violent potency and female vulnerability. It is not a difference in physical strength, but the embodiment of these social, symbolic, and cultural constructions that enables violence against women to be viewed as a "normal" and normalized part of society. Simultaneously, violence itself creates these gendered subject positions of potency and vulnerability, as well as the power or powerlessness to act. In this sense, intimate partner violence is gendered and gendering at the same time (Glammeier 2011).

In parallel to the changing perceptions of gender initiated by gender studies, there has been a shift in the perception of disability induced by the disability movement, disability studies, and political changes associated with the UN Convention on the Rights of Persons with Disabilities. While individual or medical models construct disability as a defect and impairment of the individual, the social model understands disability as a social construction and a process in which certain people (defined as different) are excluded from social participation and recognition. In this sense disability is not a personal attribute, but the result of a societal process of othering and discrimination. The cultural model further broadens this perspective by problematizing the concept of (physical) impairment and the definition of difference itself, and focussing on the social, historical, and cultural contexts that constitute disability as a problem (Dederich 2010). This means that the problem is not only discrimination as a consequence of disability, but also the categorization as (dis)abled itself. The categorizations "female" and "disabled" are associated with social constructions of vulnerability and weakness, which tend to be intensified for the construction of disabled women. In this process of defining differences, power relations are reinforced: "It is possible that women with disabilities are perceived by men who espouse a patriarchal ideology as being less difficult to dominate, which may include domination through violence" (Brownridge 2006, 809).

2. Research on Prevalence of Violence Against Women with Disabilities

Large-scale population-based research on women with disabilities is still rare today, although there are a few examples. Such studies usually use population-based data compiled for other reasons that include questions about violence. In the underlying surveys, experiences of violence are only a side issue and are generally not explored in detail using the specific methods developed to uncover the extent and contexts of violence in an appropriate, sensitive, and ethically responsible way (for specific methods see: Martinez et al. 2007; WHO 2005). Although some of these studies are relatively large-scale and include women with different disabilities, the samples are mostly not representative of disabled women as they are limited to non-institutionalized women, and to women who can be interviewed by telephone and understand the survey questions. This excludes deaf women, women with intellectual disabilities who need simple language, women with difficulties speaking, and women who cannot physically reach the telephone within the number of rings typically allowed by survey researchers, as well as women living in institutions. Furthermore, the methodology of telephone interviews may be problematic for research on intimate partner violence as it cannot be ensured that the interview is conducted in privacy and the potential perpetrator is not present during the interview (an important condition and ethical standard in prevalence research, see Martinez et al. 2007).

With respect to violence prevalence, all studies point in the same direction. Powers, Hughes, and Lund summarize (2009, 1041): "Studies using population-based and purposive samples have found that, compared to women without disabilities, women with disabilities are more likely to experience physical and sexual violence (Brownridge, 2006; Martin et al., 2006; Powers et al., 2002; Smith, 2008), increased severity of violence (Brownridge, 2006; Nannini, 2006; Nosek et al. 2001), multiple forms of violence (Curry et al., 2003; Martin et al., 2006; Nosek et al., 2001), and longer duration of violence (Nosek et al. 2001)."

Brownridge (2006), for example, conducted a study on intimate partner violence against women with and without disabilities using a random sample of 7,027 married or cohabiting heterosexual women aged 15 years or older, of

whom 1,092 were disabled. The data stem from Statistics Canada's Cycle 13 of the General Social Survey (GSS). The study employed a modified version of the Conflict Tactic Scales measuring violence as acts of physical and sexual assault (being forced into any sexual activity).

The main result was that women with disabilities had 40 percent higher prevalence rates of violence in the five years preceding the interview. These women were also at high risk of severe violence (Brownridge 2006, 805). Furthermore, Brownridge found that "perpetrator-related characteristics alone accounted for the elevated risk of partner violence against women with disabilities" (ibid.). These characteristics were patriarchal dominance, sexual possessiveness, and sexual jealousy (ibid., 813).

Martin et al. (2006) analysed a sample of 5,326 women (age 18 to 99 years) in North Carolina using data from a random digital household telephone survey (North Carolina Behavioral Risk Factor Surveillance System, NC-BRFSS) conducted during 2000 and 2001. Twenty-six per cent of these women were assessed as having a disability. The high proportion of disabled women is probably due to the relatively broad disability definition and to the fact that women aged over 65 years were included. Violence was measured as physical violence (asking the women whether anyone had "pushed, hit, slapped, kicked or physically hurt" them in any other way) and sexual violence (forced them to have sex or to do sexual things) during the past year (ibid., 827). The findings showed that the most common perpetrators were current or former intimate partners. Martin and colleagues found that disabled women had more than four times higher rates of sexual assault in the past year compared to women without disabilities, although there were no significant differences in rates of physical violence.

Smith (2008) analysed the data from the 2005 Behavioral Risk Factor Surveillance System (BRFSS) in the United States (telephone survey) regarding intimate partner violence. The sample comprised 219,911 women, 49,756 of whom identified themselves as having an activity limitation or disability. Sexual abuse was defined as unwanted sex. Physical abuse was measured with the question: "Has an intimate partner ever hit, slapped, pushed, kicked, or physically hurt you in any way?" Results showed that disabled women were 2.05 times more likely to be physically abused and 2.38 times more likely to experience unwanted sex.

3. Methods

The latest German nationally representative study on violence against women with various disabilities (physical, intellectual, visual, hearing, mental disabilities, as well as severe chronic diseases) is one of the first broad national studies to focus on violence against disabled women using specific methods that were able to reach and interview a broader group of disabled women than earlier studies. It fills some of the gaps in existing research described above and provides a relevant contribution to the questions of prevalence, risk factors, and contexts of violence against disabled women.

In 2010 and 2011, a total of 1,561 disabled women aged 16 to 65 years living in households and institutions were interviewed – alone in standardized face-to-face interviews – about their living situation, stress, discrimination, and experiences of violence in childhood, youth, and adulthood.

3.1. The Samples

Three samples were collected: (1) a representative sample of disabled women living in private households, (2) a representative sample of disabled women living in residential institutions, (3) an additional non-representative sample of blind, deaf, or severely physically disabled women. Furthermore, thirty-one women who had experienced violence were interviewed for a qualitative study.

3.1.1. Disabled Women Living in Private Households

The representative sample of 800 women living in private households was recruited using screening interviews in 28,000 randomly selected households (random route sampling procedure),[3] in order to identify women in the

3 In "Random Route" sampling interviewers are sent to randomly selected starting addresses and select households on the basis of a fixed random route plan (every 2nd, 3rd, or 4th household).

defined age group who reported having severe long-term movement, hearing, visual, cognitive, and/or psychological impairments, and/or long-term-impairments resulting from chronic diseases.[4] Most of these women had multiple impairments and thus could not be placed in specific disability categories. The most common impairments found in this group were physical (92 percent) and psychological (68 percent), or a combination of both. Besides that, 19 percent had hearing impairments, 14 percent visual impairments, 17 percent cognitive impairments, and 8 percent speaking impairments. Three quarters of the women reported more than one impairment (Schröttle et al. 2013; Schröttle et al., forthcoming).

3.1.2. Disabled Women Living in Residential Institutions

In the residential institutions sample, 420 women with disabilities were randomly selected for interview. First of all, lists of all residential homes for disabled people in twenty randomly selected regions were compiled, including the number of residents in each institution. Using these lists, twenty-five interviewees were randomly selected per region, proportionately to institutions and numbers of residents.[5]

Three quarters (76 percent) of the interviewed women living in residential institutions had intellectual disabilities and were interviewed by specially trained interviewers in simplified language using a similar questionnaire. 20 percent of the interviewed women living in institutions had mental disorders and 5 percent severe and/or multiple physical disabilities; both latter groups were interviewed with the standard questionnaire.

3.1.3. Non-representative Sample of Blind, Deaf, or Severely Physically Disabled Women

In a supplementary non-representative quantitative sample, 128 blind, 83 deaf, and 130 severely physically disabled women living in private households were interviewed using the standard questionnaire. These additional samples were required in order to include an adequate number of women with these more severe disabilities (which might be connected with greater or specific vulnerabilities). These women were recruited through newspaper announcements, NGOs for people with disabilities, and multipliers.

3.1.4. Qualitative Interviews

For the additional qualitative study, thirty-one women who had taken part in the quantitative survey and reported different forms of violence and abuse (psychological, physical, and/or sexual) were contacted for an additional qualitative interview to explore more deeply their experiences of violence and their efforts and experiences with help-seeking, support, and intervention. These guided interviews with physically, mentally, intellectually, and/or sensory disabled women were conducted in both private households and institutions.[6]

3.2. Interview Methods

All women were interviewed face-to-face by female interviewers in the household, institution, or another place where the woman could feel safe. Specific interview training was given to all interviewers in order to provide a sensitive and safe atmosphere for both interviewees and interviewers (for ethical standards in research on violence against women, see WHO 2001 and Martinez et al. 2007).

Reaching women with intellectual disabilities is very important for violence prevalence research, as they tend to be more vulnerable. For the current research, specific methods were developed to allow valid investigation of the experiences of this group and comparability with the experiences of other groups. Words and sentences had to

4 Further criteria for inclusion in the sample were: using services for disabled people and/or official registration of disability.

5 If for example three women had to be selected from one institution, this institution was contacted and asked to arrange contacts to the three residents whose birthdays were next.

6 The reconstructive-hermeneutical analysis focuses on agency, processes of positioning, and the subjective meaning of the experiences (Bethmann et al. 2012; Helfferich 2004). Rather than asking a series of questions, the interviewer invited the interviewee to narrate, emphasizing that the focus was on her experiences and explained: "The focus of these interviews is on the possibilities of support and help for women with disabilities, on support needs, and on the need for change. We would like to ask you what happened to you and what could have helped you. [Interviewer mentions the reason why the interviewee was asked for an interview, for example because of partner violence.] Could you please tell us what happened?" The complete interviewer instructions are published in Kavemann and Helfferich 2013.

be simplified and shortened,[7] the interviewers had to pay more attention to comprehension and possible manipulation. A higher degree of flexibility in the interview sequence was also necessary.

Interviews with deaf women were conducted in sign language by a team of deaf interviewers (trained by deaf researchers who intermittently joined the research team). The method of interviewing deaf women by deaf interviewers using sign language was necessary in order to ensure full understanding and trust and to minimize hierarchies between interviewers and interviewees with respect to hearing impairments, all of which might undermine the disclosure of violence.

These specific methods provided more trust and a barrier-free setting, especially for disabled women who are usually hard to reach for surveys.

3.3. Questionnaire

The questionnaire was similar to the large scale German national representative survey on violence against women in the general population (Health, Well-being and Personal Safety of Women in Germany, N=10,264, Schröttle and Müller 2004)). Questions on violence used behaviour-related item lists for physical violence, sexual violence, and sexual harassment as well as for psychological violence. There were separate questions for violence in childhood and youth and for violence in adulthood (from the age of 16).[8]

Physical violence was operationalized by a list of twenty-one items ranging from less severe forms of violence (like being pushed away angrily or a light slap in the face) to severe and very severe forms (punching, beating up, strangling, severe threat or use of weapons). The item list is a modified form of the Conflict Tactic Scales further developed and modified within German and European prevalence research contexts (see Martinez et al. 2006, 2007; and Schröttle and Müller 2004). Sexual violence was operationalized by a list of six items addressing forced acts like: "somebody has forced me to have sexual intercourse", "somebody has forced me to engage in sexual acts or practices that I did not want". Questions on sexual harassment comprised a list of fourteen items addressing acts ranging from verbal harassment and gazing, up to unwanted touching, kissing and stalking. Psychological violence was measured by a list of eleven items with various acts from verbal aggression and severe insults over severe threat and continued hassling up to psycho terror. The item lists for violent acts were followed by questions on the type of perpetrators, frequency of acts in different time frames and consequences of the violence experienced (like injuries, fear, use of institutional services and interventions). Respondents who reported acts of violence after the age of 16 were asked whether these acts had also happened since they became disabled, and which acts had been experienced within the past 12 months.

Experiences of childhood violence (up to the age of 16) were divided between sexual abuse (by any kind of perpetrator) and parental psychological and physical abuse. Parental psychological and physical abuse before the age of 16 was measured by a twelve-item scale that included psychologically violating behaviour (such as having been humiliated, pulled down, or emotionally violated) as well as physical harm and punishment (like being slapped, beaten up, beaten with something). Sexual violence in childhood was measured by a five-item scale that included being forced or pressured to touch one's own or another person's intimate parts as well as other forced/pressured sexual acts up to the age of 16 (asked separately for adult perpetrators and children or adolescents as perpetrators).

A respondent was defined as victimized by a form of violence when at least one act from the item list had been experienced. Severe forms of violence were defined by the

7 For example, the question of life satisfaction with respect to the family situation was not based on a differentiated scale as in the everyday -language questionnaire. Instead the answer categories were "rather satisfied" / "rather dissatisfied". The question "How satisfied are you with your family?" was explained by the interviewer if necessary: "Are you fine with your family? Or are you not fine with your family? For example with your mother [pause], your father [pause] or your siblings?"

8 The survey was based on international VAW prevalence research methods developed within the European prevalence research context (see Martinez and Schröttle et al. 2006, 2007).

severity of acts, the consequences of acts (physical injuries), and the perceived fear or threatening character of situations.

Besides these questions on violence, further questions on discrimination, living situation in institutions, barriers and burdens in daily life, and dependence on care were included in order to investigate the specific problems and life situation of disabled women. These additional questions were very important for acquiring a better understanding of the connections between disability, discrimination, and violence.

3.4. Data Analysis

The data was analysed with SPSS. For the first report mainly uni- and bivariate descriptive analyses were conducted. For comparisons between groups significance tests (predominantly chi-square and t-tests) were used.

4. Findings

4.1. Quantitative Study: Prevalence and Risk Factors

The prevalence rates obtained in the representative general population sample (Schröttle and Müller 2004) were used as a basis for comparison between disabled women and the general female population. Prevalence rates of psychological, physical, and sexual violence are alarmingly high among women with disabilities.

4.1.1. Prevalence Rates for Violence in Adulthood and Intimate Partner Violence

Table 1 shows that women with disabilities experienced physical, sexual, and psychological violence to a great extent and by different kinds of perpetrators in their adult lives. Violence by current and/or former intimate partners was experienced at about two to five times higher prevalence rates than in the general female population.[9]

Table 1: Prevalence of psychological, physical, and sexual violence in adulthood (since the age of 16)

	Case basis: All respondents (multiple responses possible)						
	Representative household and institution survey				Non-representative supplementary survey		
	General population (BMFSFJ 2004) N=8,445 (%)	Households N=800 (%)	Institutions/ everyday language N=102 (%)	Institutions/ simplified language N=318 (%)	Deaf women N=83 (%)	Blind women N=128 (%)	Severely physically disabled women N=130 (%)
Psychological abuse*	45	77	90	68	84	88	78
Psychological abuse by intimate partner	13[1)]	25	28[2)]	(4)[2)]	45[2)]	33[2)]	28[2)]
Physical violence*	35	62	73	58	75	66	59
Physical violence by intimate partner	13[1)]	29	36	(6)	41	22	25
Sexual violence*	13	27	38	21[2)]	44	29	29
Sexual violence by intimate partner	4[1)]	13	20	(6)[2)]	19	13	14

* Including violence by all kinds of perpetrators (unknown or known persons, family members, intimate partners, friends/acquaintances, neighbours, perpetrators from school, education and work, from institutions as well as other persons, measured by a detailed perpetrator list).

() parentheses: small number of cases (<=5)

1) Data on partner violence refers only to oral questionnaire to maintain compatibility with current study with disabled women

2) Higher rates of non-response than in other groups.

9 Depending on different groups of disabled women and the different types of violence. Prevalence rates reflect the proportion of persons who reported at least one of the acts of the item lists for physical, sexual and psychological violence. The age limitation for violence in adulthood was after the age of 16.

13 percent of women in the general population,[10] but 25 percent to 45 percent of disabled women – depending on the sample – reported psychological abuse by intimate partners (lifetime prevalence). With respect to physical violence, 13 percent of women in the general population reported physical violence by intimate partners compared to 22 to 41 percent reported by disabled women, which is a two- to more than threefold higher risk of violence). While 4 percent of the general female population reported forced sexual acts by intimate partners, this was the case for 13 to 20 percent of disabled women, which represents a three- to fivefold higher risk of sexual violence through intimate partners for disabled women. With respect to physical and sexual violence by intimate partners, deaf women and women with mental disabilities living in residential institutions were the most seriously affected groups. Psychological abuse by partners was reported most often by deaf and blind women. Women with intellectual disabilities experienced violence by different perpetrators to a high degree, too, but they reported intimate partner violence less often. This might be explained by the fact that they are less often partnered (65 percent of them had at least one intimate partner during their life, which was the case for 81 to 96 percent of women in other reference groups). Furthermore, women with cognitive disabilities had higher rates of non-response to these questions. Besides that the differences in intimate partner violence between women of the general population and disabled women living in private households cannot be explained by these factors as rates of partnered women (and rates of nonresponse) were similar for the household samples.

4.1.2. Violence in Childhood and Youth as Risk Factor

The high prevalence of intimate partner violence, as well as the high prevalence of sexual violence since the age of 16 reported by disabled women seem to be connected with earlier experiences of violence in childhood and youth. Table 2 shows a significantly higher rate of psychological abuse from parents as well as a two- to three times higher rate of sexual abuse in childhood and youth for women with disabilities compared to women in the general female population.[11] Except for intellectually disabled women who often could not remember experiences in childhood and youth, all women with disabilities reported high rates of psychological abuse by parents (52 to 63 percent vs. 36 percent in the general population) and sexual abuse by adults (20 to 34 percent vs. 10 percent in the general population) and/or by child and adolescent perpetrators (9 to 36 percent; no comparison with general population possible). When lifetime experiences of sexual violence before and after the age of 16 are taken together, more than every second to third disabled woman had experienced sexual violence during her life; deaf women and women with mental disabilities were, again, affected most often.[12]

10 Referred to the data from the oral questionnaire of the former prevalence study, which is comparable with the current study on violence against women with disabilities.

11 Significance tests (t-test) were conducted for differences between the general population and the representative household and institution samples. Significant differences were found for all forms of violence in childhood between non-disabled women and women with cognitive disabilities; for the other two groups of disabled women significant differences to the general population were found with respect to psychological and sexual violence by adults.

12 Men with disabilities might be a vulnerable group, too. A new study conducted by our research team with disabled men living in households found higher overall rates for physical and psychological abuse in adulthood, but no higher rates for intimate partner violence, sexual violence, or violence in childhood and adolescence (Hornberg et al. 2013).

Table 2: Prevalence rates of physical, psychological and sexual violence in childhood and youth[1)]

	Case basis: All respondents (multiple responses)						
	Representative household and institution survey				Non-representative additional survey		
At least one act experienced	General population (BMFSFJ 2004) N=8,445 (%)	Households N=800 (%)	Institutions/ everyday language N=102 (%)	Institutions/ simplified language N=318 (%)	Deaf women N=83 (%)	Blind women N=128 (%)	Severely physically disabled women N=130 (%)
1. Physical or psychological abuse by parents							
Physical and/or psychological violence by parents	83	88	93	58	90	83	82
Physical violence by parents	81	85	90	55	83	77	74
Psychological violence by parents	36	53	61	34	59	63	52
2. Sexual child abuse							
By children, adolescents or adults	--[2)]	30	36[3)]	25[3)]	52	40	34
By adults	10	24	31[3)]	20[3)]	34[3)]	34	25
By children and/or adolescents	--[2)]	11	10[3)]	9[3)]	36[3)]	17	14

[1)] Different case basis. Paragraph 1: all respondents that grew up with their parents. Paragraph 2: all respondents.
[2)] Question not asked in general population survey.
[3)] 10 to 16 percent non-response.

4.1.3. Living Situation and Type of Disability as Risk Factors

The quantitative study found differences in the affectedness and character of violence experienced referring to living situation, duration of disability and type of disability. Women living in institutions rarely experienced violence by current partners as most of them (58 to 66 percent) were not living together with a partner. Here, violence perpetrated by other disabled residents or staff in institutions plays a more significant role and is the form of "domestic violence" they experience. Women with mental disorders living in institutions reported high prevalence of violence in childhood and adolescence (see Table 2), as well as high prevalence of violence by former intimate partners that might have contributed to mental disorders.

The risk of intimate partner violence, the level of violence (with respect to the severity and the consequences of violence such as injuries), and the levels of fear of violence also depended on the severity of the disability and the current living situation.[13] The more burdened and dependent the current living situation was, the higher were the rates of intimate partner violence. Furthermore perceived threat, feelings of defencelessness, and higher levels of fear of violence in everyday situations were most pronounced for deaf, blind, and severely physically impaired women in the supplementary survey. These women linked violent experiences significantly more often with their disability. In addition, women in the supplementary survey were not only affected by intimate partner violence to a high degree, but also experienced violence to

13 Severity of disability was measured by questions on the degree of restriction with respect to several life situations (such as housework, employment, leisure, social activities, family, partnership, or vital activities such as eating, drinking, using the toilet alone). Further indicators were specific disabilities like being blind or deaf, as well as a high level of dependency on assistance in daily life.

a greater extent in all other contexts – by unknown or barely known perpetrators in public places as well as by persons in the workplace and the neighborhood, and by friends and acquaintances. These circumstances could have created a perception of the environment as potentially violent and threatening, and represent further factors that encourage these women to remain in violent partnerships.

4.2. Qualitative Study: Relationship Dynamics, Disability, and Violence

In the additional qualitative study (Kavemann and Helfferich 2013) thirty-one guided interviews were conducted with women with disabilities who had experienced psychological, physical, and/or sexual violence. They talked about multiple experiences of different forms of violence through their lives. The women's narratives about their experiences, relationship dynamics, ambivalences, problems of separation, traumatic violence, and traumatic bonding are very similar to the experiences of women without disabilities, but the context of disability gives them a particular colouring. Additionally, disability-specific aspects of relationship dynamics and violence experiences were found. For this article some interview quotes (ibid.) have been abridged and translated.

Women who experienced intimate partner violence described it as a kind of continuation of experiences from childhood and adolescence. For some women, violence in childhood was regarded as normality. Sometimes the violence was excused: "My mother often beat me, because she was overwhelmed with the situation. I think she just couldn't bear that I was blind. And when I was clumsy, she felt guilty and couldn't come to terms with that" (ibid. 32). This made the women themselves feel guilty about being disabled. One described the feeling of rejection: "I loved my mother, but I just didn't please her and that was bad. That was really terrible" (ibid., 73). In later life, these women felt that their partners treated them in the same way their parents had. The disabled daughters' experience that their parents felt ashamed of them, that they were perceived as a disappointment and as a burden led to feelings of guilt and shame. This was intensified when the parents taught their daughters to be modest and grateful for any attention.

The women's great emotional neediness was a recurring theme in the interviews, especially their desire for affection, caring, intimacy, and bonding. It seems to be connected with deprivation and experiences of discrimination and emotional violence during childhood accompanied by the development of low self-esteem. The neediness and the feeling of worthlessness led to elevated vulnerability to partner dominance and violence, to dependence, and to the feeling that there is no alternative to the situation:

> "I couldn't get away from him. Probably because my mother had rammed the idea into me that I had to take what I got because I was disabled." (ibid., 46)
>
> "My father always told me I only had a right to be in a kennel." (ibid.)
>
> "If I left him [the perpetrator], I would be very lonely, so I keep on walking a fine line." (ibid., 47)

Dependencies and self-esteem problems also had negative effects on seeking help and support. Low self-esteem as a result of education and socialization hinders both disabled and non-disabled women from making demands on or leaving a partner. But the disabled interviewees described this experience as directly linked with their disability. The isolating effects of disability and violence made it even more difficult for the disabled women to seek help. This is aggravated by the fact that most support services are not accessible for disabled women. Particular difficulties in seeking help became obvious regarding women living in institutions. They had no possibilities for actively seeking help and claiming their rights by themselves. Furthermore, women with intellectual or mental disabilities are often regarded as less credible and reliable.

5. Discussion

The findings show that women with disabilities experienced psychological, physical, and sexual violence and abuse by different perpetrators two to three times more frequently than women in the general population. Differences in life situation, type of disability, and discrimination shape the structure and background for greater vulnerability. Violence experienced in childhood and adolescence and disempowering constructions of disabled girls and women also play an important role.

5.1. Risk Factors and Causal Contexts

5.1.1. Destructive and Weakening Childhood Experiences

Research on violence against women has described the destructive influence of childhood abuse on the victimization of women in their adult lives (Abramsky et al. 2011; Schröttle et al. 2006; Stith et al. 2004). Some studies have found that the risk of victimization through intimate partner violence is increased two- to threefold when women have experienced violence in childhood and youth (Schröttle and Müller 2004). The very high levels of parental violence and sexual abuse against women with disabilities in childhood and youth seems to be one of the key risk factors for greater vulnerability and greater incidence of intimate partner violence and sexual violence (by partners or other persons) in adulthood.

Moreover, deaf (38 percent) and blind women (14 percent) often spent their childhood and youth in institutions, especially in residential schools and homes for disabled people. In these groups, very high levels of sexual violence in childhood and youth (40 to 52 percent) were found.[14] Both the early time spent in institutions as well as early childhood experiences of sexual violence heightened the risk for later intimate partner violence.

The qualitative interviews with victimized women with disabilities showed how experiences of discrimination, neglect, and violence in childhood tend to undermine the ability to set boundaries. Their early experiences led to a great emotional neediness and low self-esteem. This contributed to an increased vulnerability for partner dominance and violence, to dependency, and to the feeling that there is no alternative.

5.1.2. Discriminatory and Disempowering Social Constructions

These results are consistent with earlier research about discriminating experiences and practices increasing the vulnerability of disabled girls and women. Chenoweth (1996) for example showed that overprotection and containment of disabled women as eternal children interferes with the development of a realistic expectation of the risk of violence (which could be helpful in facing violence when it occurs or avoiding getting into violent situations; ibid.: 404). Referring to Sobbey (1994), she emphasizes that women with disabilities are often taught unquestioning compliance, which hinders their ability to draw appropriate boundaries. Curry et al. (2001, 74) argue that for "women with disabilities, leaving may mean risk of losing their independence and the risk of institutional care". Hassouneh-Phillips and McNeffs (2005, 227) emphasize that the perception of disabled women as sexually inadequate and unattractive and their desire to be partnered increase women's vulnerability to staying in abusive relationships for a long duration.

Deaf women, who were affected by intimate violence to a high degree were mostly living together with deaf intimate partners and embedded in social relationships with deaf friends and deaf acquaintances. Here additional risk factors could be relevant, like isolation from, and a lack of assistance and support by, hearing people. A further influencing factor that was discussed by parts of the deaf community and also reflected in the results of the current study: More traditional gender constructions within the deaf communities might contribute to higher levels of intimate partner violence. Especially the construction of deafness as weakness and the construction of dominant masculinity and aggression might contribute to role conflicts and aggression that should be analysed more thoroughly.

Another factor that tends to disempower disabled women – in contrast to women without disabilities – is desexualization and the construction of disabled women as not being attractive partners for intimate relationships. With respect to women with cognitive disabilities, the hypothesis of Chenoweth (1996) is important. She argues that the social construction of disabled women as asexual and simultaneously promiscuous and depraved increases their vulnerability.[15] Sexual violence against an asexual being who would "never

14 Cognitively disabled women were also institutionalized in childhood and youth (15%) but could often not remember early experiences of violence. 10 to 16% did not respond to the questions on sexual abuse before the age of 16.

15 This argument is often expressed by practitioners working with intellectually disabled women and men but it was seldom reflected that promiscuity might be a consequence of early and ongoing experiences of violence and/or the lack of sexual education.

attract a sexual partner" and/or who has "no feelings" seems to be less important in the perspective of society and perpetrators. The common failure to offer adequate sex education for intellectually disabled people seems to be based on the assumption that disabled women do not need to know about sexuality, which is not and should not be part of their lives, because if they were informed, they would be uncontrollably promiscuous (Chenoweth 1996, 405). For women who do not know about sex, it is much more difficult to talk about sexual violence and to turn to others for help. Moreover, if these women are seen as promiscuous they can be accused of having provoked the sexual violence, which can save the perpetrator from (legal) accusation.

5.1.3. Interdependence of Violence, Disability, and Health

Childhood experiences of violence can contribute not only to experiences of violence in adult life but also to severe health problems,[16] psychological problems, and disabilities in later life. Even disabled women who were not disabled in childhood reported higher rates of parental psychological and sexual abuse in childhood and adolescence in comparison to the general population. This suggests that disability might often be a consequence of earlier childhood experiences of violence and vice versa: both violence in childhood and youth as well as disabilities can contribute to a higher vulnerability to intimate partner violence in the adult lives of disabled women. Thus, the current study reflects the high relevance of violence for girls' and women's health, which was found in several studies (Campbell 2002; Martinez et al. 2006; Schröttle et al. 2009) and stressed by the World Health Organization (WHO 2001). Moreover, the current study highlights the interdependence of violence and disability which has to be taken into account in studies on violence against disabled women. Thus, it is not only disability that makes women more vulnerable to violence, but also violence that makes people more vulnerable to health impairments, disability and continued victimization. These correlations may be exacerbated by the isolation and discrimination that many women with disabilities experience, thereby making them more dependent on violent partners.

In their study with disabled women, experts, and organizations Hague and colleagues (2008b, 3) argue that current definitions of domestic violence are too narrow to encompass the range of experiences of disabled women. Their interviewees stressed that the disability made the abuse worse and made it more difficult to escape. Hague and colleagues found a high extent of sexual, physical, financial, and verbal abuse that was directly connected with women's impairments, reinforcing control by and dependency on their abusive partners (ibid.).

5.2. Consequences for Prevention and Intervention

The greater vulnerabilities of disabled women will have to be taken into account more carefully in the ongoing development of prevention and intervention strategies without stigmatizing disabled women as victims. The results of the current study underline the findings of Hague and colleagues (2008a) with respect to barriers to help-seeking, which are a consequence of the lack of adequate barrier-free services for disabled women on the one hand. On the other hand inner barriers formed by discriminatory perceptions of disabled women weaken their self-esteem and limit the belief to have the right to live without violence and the right to get support.

The poor service situation is especially alarming given that disabled women experience violence more often and are affected by even more severe abuse. Thiara et al. (2012, 33) describe a vicious circle: Disabled women experience more severe abuse because they stay longer in abusive relationships, and the longer duration of abusive relationships is due to the paucity of appropriate and knowledgeable service provision.

Several central recommendations for good practice and strategic development of support, counselling, and other

16 Psychological problems were not only mentioned by women living in institutions because of mental disabilities, but also by a high percentage of women in households with other disabilities (58% to 75%).

sectors have been formulated by Hague and colleagues (2008a, 83ff). Their suggestions include more comprehensive services for disabled women experiencing domestic violence in all sectors; training and awareness-raising in all relevant sectors (to counter myths about disability and domestic violence, challenge prevailing attitudes, and overcome fear, anxiety, and lack of commitment among service providers); improving awareness of the high affectedness of disabled women experiencing violence by several perpetratrors (through intimate partners, but also through other perpetrators like personal assistants, other carers, and family members); and allocating dedicated resources and involving disabled women in service and policy development.

5.3. Consequences for the Political Discussion

Women with disabilities are not victims per se, but the social constructions of disability and gender that lead to discrimination increase their vulnerability. In this sense, improving the life situations of disabled women not only means improving support and services (including a differentiation in need assessment according to the type of disability) and reducing barriers, but reflecting on the categorizations and social, cultural, and symbolic constructions underlying violence against women with disabilities that have contributed to their exclusion and discrimination.

For a long time women with disabilities have been "voiceless", and their experiences of violence have been largely invisible in both the disability and the women's movements (Chenoweth 1996; Thiara et al. 2012). This is changing, and women with disabilities have established political lobbies to assert their rights and to draw attention to discrimination and violence against disabled women. This may contribute to changing the perception of disabled women as passive victims and strengthening concept of disabled women as subjects of the discourse and as political actors.

5.4. Reflections on Methods: Success and Limitations of the Current Study

The current study is one of the first to succeed in including a broad range of women with different disabilities in different life situations – most of them by random sampling – and interviewing them about lifetime experiences of violence in a similar and sensitive way. Therefore specific methods to reach different groups of women were developed that could reach disabled women who are usually not included in surveys. The method of interviewing deaf women by deaf interviewers was methodologically very successful. Producing valid and comparable structured interviews with women with intellectual disabilities is still rare in empirical research but, as the example of the current research shows, it is possible and promotes the inclusion of intellectually disabled women by taking them seriously in empirical research. Of course, this is limited to respondents who can give informed consent and follow a simplified version of the interview. The experiences of more seriously intellectually disabled women will have to be investigated by other methods (such as expert interviews and/or interviews with trusted contact persons.

By sensitive questioning and thorough training of interviewers, a respectful and non-harming, boundary-keeping manner of interviewing could be provided. This was effective in ensuring the confidence of interviewees and uncovering an unexpectedly high rate of violence against these women in childhood and youth that leads to severely increased risks of victimization for women with disabilities.

The methodological considerations built a framework that provided more differentiation than in earlier studies. It allowed us not only to compare disabled to non-disabled women but also to differentiate between women with various types of disabilities. Thus, we were able to investigate differences with respect to type and seriousness of disability, housing, discrimination, and exclusion that are basic preconditions for different experiences of latent and manifest violence by partners and/or other potential perpetrators. With respect to differentiation and risk factors, the analyses of the available data of the study have still not been completed. Further secondary analyses in national and international research would be useful.

The methodology of this study was successful in exploring in greater depth the life situations of women with disabilities. The study has limitations in terms of represen-

tative sampling of deaf, blind, and severely physically and/or multiply disabled women. These women could not be found to a sufficient extent by random route sampling in households because the prevalence of these disabilities in the population is very low. The attempt to reach these women with the support of the relevant social security agency (Versorgungsamt) was not successful due to a low response rate. Therefore a supplementary convenience sample was necessary, which produced selections, e.g. of more educated women . To achieve representative samples from these groups, greater financial resources are necessary.

Reflecting on the methodology adopted in our study, it can also be concluded that interviewers in research into violence against women should be female and specifically trained for their task to gain the skills for sensitive and safe interviewing and to overcome uncertainty and prejudice. Methods for the safety of interviewers and interviewees should be taken: interviews have to be conducted alone and face-to-face without the presence of family members or other third persons. Interviewers should be prepared to avoid too much stress for respondents during the interviews and provide information on counselling for interviewees in case they need or want further information or assistance. Additional qualitative studies can deepen the understanding and interpretation of the quantitative data.[17]

One of the central problems of current prevalence research is that it is often not suited for reaching vulnerable groups and investigating their experiences of violence within the societal framework of specific forms of exclusion and discrimination in a comparative, sensitive, and respectful way.[18] We hope that this study of violence against disabled women in Germany may contribute to the ongoing development of methodology and inspire scientific discussion of this aspect.

17 Further methodological requirements are described by Nosek, Howland, and Hughes (2001).

18 This has been discussed with respect to research on violence against women from ethnic minority groups (see Thiara, Condon, and Schröttle 2011).

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