



VIOLENCE-INDUCED DISABILITY

THE CONSEQUENCES OF VIOLENCE
AGAINST WOMEN AND CHILDREN

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DEDICATION

This paper is respectfully dedicated to those whose lives and stories have informed the research. DVIRC is grateful for permission to use their words and indebted to those who have recorded their experiences elsewhere.

VIOLENCE-INDUCED DISABILITY:

THE CONSEQUENCES OF VIOLENCE AGAINST WOMEN AND CHILDREN

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Introduction

How many women experience . . . disability as a result of family violence? Well we don't know. No one is counting (Jennings 2004: 3).

We are women of broken spirits, broken bodies and broken minds. Not so much because of impairment or disability, but as a result of violence . . . our disabilities are intimately tied to our experiences of violence because we were shot, shaken, blinded, beaten or psychologically tortured (Doe et al 1999: 1).

This paper explores one of the links between domestic and family violence and disability in Australia, in the form of violence-induced disability. It therefore differs from most of the literature on violence and women with disabilities, which focuses on disability as a risk factor affecting the likelihood of violence being perpetrated against these women. Disabilities resulting from violence are typically incorporated into this literature in a peripheral way.

In contrast, this discussion considers violence and disability in a causal relationship. It does not seek to depict domestic and family violence as the sole cause of disability for women, for even amongst disabilities that are most closely aligned with indicators of violence there may well be other causes. Nor does it seek to depict disability as never pre-dating domestic and family violence. Instead, it explores how domestic and family violence may precipitate disability, or further disability.

If violence against women is comparatively under-researched, then domestic and family violence against women and children with disabilities constitutes an even smaller field of study. Within that literature, the examination of violence as a cause of disability is an almost un-navigated backwater. Nevertheless, a small group of researchers has produced what little is known in western societies, outside of the individual lived experiences of the women and children who have, in the main, been its victims. This research largely comes from Canada, the US and the UK. Very little is currently known about the phenomenon in Australia.

This paper is therefore as much about gaps in our knowledge as it is about what we know. It draws together various threads of research and anecdotal evidence that link women's

and children's experiences of violence and disability, and notes the lack of data which forms a fundamental stumbling block in efforts to advance awareness of the issue. The paper also explores what data collection methods are currently available, and their limitations, as well as some of the issues with establishing or improving the collection of data.

This paper has primarily been written to raise public awareness and discussion. It is aimed at a broad audience including policy-makers, educators and service providers. However in recognition of the fact that the experience of disability and violence is isolating, it also aims to increase women's understandings that they are not alone in dealing with the aftermath of violence.

The paper draws upon three sources of material. Consistent with the feminist practice of providing a platform for women's voices to be heard in the public sphere, face-to-face discussions were held with women with violence-induced disabilities. In addition, the paper includes scenarios drawn from children's experiences, as reported by workers in the field. Thirdly, it refers to published material (academic literature, material produced by women who have experienced disability following violence, and government publications).

Finally, the paper raises the question of what we might aspire to in respect of stopping violence-induced disability. This is a preventable phenomenon and yet in our society, violence against women and children is tolerated on a practical level. While a recent government campaign proclaims that 'Australia Says No' to violence against women, as a society we consistently resile from actively condemning domestic and family violence in a meaningful way by taking effective action to stop it.

Framing the Problem: Terminology

This paper broadens horizons around some of the phrases and terms used in discussions of domestic and family violence and disability. The following definitions aim to give the reader an understanding of the particular phrases 'domestic and family violence', 'carers', 'disability' and 'violence-induced disability'. The terms 'vulnerable' and 'elder abuse' are also briefly dis-

cussed, since they carry particular discursive baggage in discussions of violence and disability.

'Domestic and Family Violence'

In this paper the term used for violence which takes place in interpersonal relationships is 'domestic and family violence'. An earlier DVIRC Discussion Paper, *What's in a Name?* (MacDonald 1998), critically analysed the different terminology used to describe these forms of violence, suggesting that of them all, 'family violence' was the most inclusive. Since then, both government and community organisations have begun to use the term 'domestic and family violence' for the same inclusive reason.

By 'domestic and family violence' we mean those forms of violence that are perpetrated (in the main) against women and children, their property and pets, in their primary place of residence.¹ Domestic and family violence is overwhelmingly perpetrated by men who are known and/or related to these women and children, and social norms and the law offer little, if any, sanctuary to them from the violence.

As *What's in a Name?* noted, however, 'domestic' is a problematic term in situating where this violence takes place. For some women, the 'home' is a residential facility, a prison, a detention centre, shared housing, a nursing home, an aged care facility, college housing, a hospital, or even the street. Such domestic spaces may be in metropolitan, rural, remote or regional areas; near to family and social networks, or interstate or in another country.

'Carers'

As women and children with disabilities may live with carers rather than family members, definitions of domestic violence need to be 'sufficiently broad to cover spousal relationships, intimate personal relationships (including dating relationships and same sex relationships), family relationships (with a broad definition of relative) and formal and informal care relationships' (Frohman and Salthouse 2004: 6).²

Special attention must be paid to those who interact with women and children with disabilities on a regular basis as part of a care team or support network. A woman or child with a disability may have a variety of people who provide assistance

¹ For an in-depth discussion of the research into the incidence of domestic violence against men, see Atmore 2001.

² Here, we are specifically talking about unwanted relationship factors, as distinct from intimate relationships which women have chosen for themselves. For many women with disabilities the issues of sex and sexuality, relationships and childbearing are areas in their lives where many barriers exist to enacting an ordinary human desire for sexual and other relationships. Women with disabilities want barriers to their own choices about intimate relationships removed (Burns 2002, Ball undated).

with many aspects of their lives, often on a daily basis. Some of these will be involved in intimate physical and emotional contact. Carers can include 'attendants, interpreters, homemakers, drivers, doctors, nurses, teachers, social workers, psychiatrists, therapists, counsellors, and workers in hospitals and other institutions' (NCFV 1992: 2). Such people are a 'family' of carers.

'Disability'

This is also a complicated term, used to describe an extremely wide range of conditions. According to the Australian Bureau of Statistics (ABS), one in five people in Australia have a reported disability, defined as 'any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities' (Glossary, ABS 2003). Under this definition, examples include everything from the use of a hearing aid, or difficulty dressing due to arthritis, through to advanced dementia requiring constant help and supervision. Disability can also be divided into discrete categories, such as physical, mental, intellectual, cognitive, sensory, psychological and emotional disabilities; and into levels of severity or persistence. Disabilities may be labelled impairments, chronic health conditions, functionality disorders, and so on.

In addition, many people argue for a social definition of disability. In this paper, the reference points for defining the word are taken from those set out in the Strategic Consumer Advocacy Project for Women with Disabilities (Waters 2004), as well as from women's own understandings of what constitutes their disabilities. These use the social model of disability which understands that a person's capacity to function in society 'is determined largely by the extent to which society recognises and responds to' their needs, and so enables them 'to participate more fully in work, leisure and family life' (Meekosha cited in Waters 2004: 16-17).

The social model challenges biomedical definitions that locate disability within individuals. Instead, it understands the term disability is influenced by cultural and political perspectives (Finkelstein cited in Waters 2004: 16-17), as well as government and service provider requirements to determine eligibility for payments and services (Frohman cited in

Waters 2004: 16-17).³ For example, the domestic and family violence experienced by Indigenous women takes place in a broader cultural context which can also be disabling: they are unlikely to report the violence they experience in the fear that it will result in the removal of their children.⁴

Women with disabilities understand their situation based on their lived experience of disability. They commonly make use of medical and biomedical terms which are also used by many of the public institutions with which they come into contact, even though these exclude the full gamut of disabling experiences.

As the topic of this paper is specifically disabilities that have been brought about through violence, it is assumed that victim/survivors would prefer not to have these disabilities. However we acknowledge that women whose disabilities have a different aetiology may experience them as a normal part of life.⁵ Nevertheless, no matter what the cause of the disability, it comes with secondary experiences of discrimination, social revulsion, poverty, marginalisation, exclusion, rejection and victimisation which are not ameliorated by the fact that a disability resulted from violence.

'Violence-Induced Disability'

Many of the impacts of domestic and family violence initially manifest as short-term health conditions or responses to trauma. Left undiagnosed or untreated (as they are likely to be), or treated inappropriately, these injuries have potential to develop into disabling conditions. For example, broken bones, post-traumatic stress disorder (PTSD), and anxiety can each be the foundation of longer term disabilities.

The likely disabling effects of violence are more frequently discussed in the literature in respect of children. As yet, not much specifically describes the disabling impacts of violence on adult women. Disability is sometimes mentioned as a factor increasing marginality, and sometimes mentioned in health surveys or research as an outcome of family and domestic violence. In respect of violence, disability is most often mentioned:

- as a factor which makes people more vulnerable to violence (Howe and Salthouse 2004, Howe 2000, NCFV 1992);
- as an additional layer of discrimination when accessing services (Meekosha 2000, Hastings 1998, Howe and Salthouse 2004);

³ The social model of disability influences definitions now employed in population surveys and research by organisations such as the World Health Organisation and the Australian Bureau of Statistics (see Appendix).

⁴ This fear has a foundation in their historical (HREOC 1997) and contemporary treatment. In 2005 the Australian Institute of Health and Welfare reported that 'In all jurisdictions, the rate of Indigenous children on [protection] orders was higher than the rate for other children. In Victoria, the rate for Indigenous children was 11 times the rate for other children' (AIHW 2005: 38).

⁵ A colleague described her knowledge of a deaf woman who remained optimistic throughout her pregnancy that her baby would be born deaf so that mother and child could share a common and, for her, familiar and comfortable environment.

- as a cause of the violence being minimised, for example when someone seeks support following violence and is referred to a disability service, rather than the violence being addressed as the primary issue (Cockram 2003, Howe 2000); or
- as a magnified difficulty when people seek legal redress (Howe 2000, Frohmader and Salthouse 2004).

Where discussion does include disability and the impacts of violence, the mental health and intellectual disability literature is far more widely available and detailed (Howe 2000).

Due to the known incidence and prevalence of violence against women with disabilities (Chappell 2003, Howe 2000) it is relevant to note that, while the discussion in this paper considers disabilities that are directly attributable to violence, this necessarily includes women who already had some level of disability prior to violence occurring, as well as those who did not.

'Vulnerable'

The term 'vulnerable' to describe the relationship of women and children (generally) and women and children with disabilities (in particular) to the risk of violence, is used here with a caution. That women and children are 'vulnerable' to violence tells us more about men, our community and its cultural values, than it does about women or children. Similarly, describing those with disabilities as being vulnerable has the effect of locating the problem with them: 'If only they weren't so vulnerable' (i.e. were stronger, more articulate, more believable), and 'They need to be protected' (sheltered, shielded, shut away, even sterilised). It is equally as valid to focus on the factors that make some women and children vulnerable to violence. Why do its perpetrators select particular people as their targets? Why are the social institutions that were established to protect all citizens, less readily accessible to, and accepting of, women and children with disabilities? Why is the community less outraged at violence against women and children with disabilities?

Describing women and children with disabilities as vulnerable masks personal and social responsibility for violence. A perpetrator who chooses a woman or child with a disability or disabilities understands he will probably get away with the

behaviour and perhaps thinks he is entitled to inflict it. This is a choice based on understandings of power relationships and it encompasses social attitudes to women and children with disabilities. In turn, these attitudes limit the means of protection or redress that are open to women and children with disabilities. The rate of violence against women and children with disabilities is greater than the rate against women and children in general; and the rate at which women or children with disabilities bring prosecutions against perpetrators is likely to be lower than for women and children in general (see, for example, Frohmader and Salthouse 2004).

'Elder Abuse'

As a gender-neutral concept, the framework in which elder abuse is understood tends to make invisible that part of the abuse of elderly people that is actually domestic and family violence. It makes the abuse sound like a problem of aging.

Domestic and family violence is a significant problem for older women. The Australian Bureau of Statistics' Women's Safety Survey (1996) found that 1.2 per cent of women aged over 55 years had experienced some form of partner abuse in the twelve months prior to the survey (cited in Morgan Disney 2000: iii).⁶ This violence may be a continuation of violence perpetrated against them throughout their lives, though it may only come to others' notice when the woman is elderly. It can take many years for such women to reach out to services or professionals, who are in danger of then mistakenly identifying the problem as 'elder abuse'.

In our society, there can be a sympathetic response to carers who perpetrate violence against older people in general, and older women specifically. A carer's actions may be excused or legitimised on account of the 'trouble' caused by the victim. As Brandl and Raymond have argued, 'elder abuse and adult protective services workers have been trained to identify, assess and intervene in elder abuse cases as instances of caregiver stress, not domestic abuse' (cited in Mears 2001: 3; see also Brandl 2000, Morgan Disney 2000, Bottrill and Mort 2003).

Women who have been the lifelong victims of violence by their partners may also find themselves in the position of being the abusive partner's only available carer later in life. In this way, they are compelled to provide succour to a perpetrator.

⁶ Rates of violence against older women are probably actually a good deal higher than figures quoted here (Morgan Disney 2000, Mears and Sargent 2002) as for older women there are particular barriers to reporting violence or attempting to change living arrangements (see Hightower *et al* 2001: 40-47).