SERVING VICTIMS/SURVIVORS WITH DISABILITIES ON CAMPUS

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ENHANCING VICTIM SERVICES PROJECT

*Note: Both the terms victim and survivor are used in this document, as each individual who experiences sexual violence may identify differently throughout the recovery process.

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INTRODUCTION

The Guide to Serving Victims/Survivors with Disabilities was created by the Rutgers Center fore Research on Ending Violence (REV) as part of the Enhancing Victim Services Project. The project aims to strengthen direct services for all victims/survivors on Rutgers' four campuses and expand the university-wide response to interpersonal violence. Students from populations that are marginalized, including students with disabilities, can benefit from targeted programming and outreach to meet their needs (Linder, 2018; McMahon et al., 2020; Roskin-Frazee, 2020). This guide aims to explore the ways campuses can improve services for student victims/survivors with disabilities based on the literature and best practices.

Violence perpetrated against people with disabilities can be similar in many ways but also may differ from violence against those without disabilities. This guide will cover the unique ways students with disabilities experience intimate partner violence (IPV), sexual violence, and disability abuse and the prevalence of these types of violence. It will then discuss the health effects of violence against people with disabilities and barriers to accessing help. Finally, this guide will offer recommendations based on best practices for serving victims/survivors with disabilities on college campuses.

DEFINING DISABILITY

Disability status is one aspect of an individual's identity that intersects with many others, such as race, ethnicity, sex, gender identity, sexual orientation, and socioeconomic status. Disability is a common experience; approximately 1 in 4 adults in the United States has at least one disability, a significant portion of whom experience multiple disabilities throughout their lifespans (Okoro et al., 2018). Individuals experience disability differently based on the intersections of their identities, the nature of their disabilities, and other individual- and community-level factors.

Disability is traditionally defined through a medical model, which views disability as requiring treatment and rehabilitation (Dirth & Branscombe, 2017). This model does not acknowledge the social construction of disability and places all responsibility on the individual whose body and/or mind is considered disabled (Dirth & Branscombe, 2017). The Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 use the medical model to define disability as physical or mental impairments which limit major life activities; these categories are pertinent for use in higher education settings because of the ADA's relevance to freedom from discrimination in education on the basis of disability status (Rehabilitation Act, 1973; ADA, 1990).

In contrast, the social model of disability (Oliver, 2013; Barnes, 2019) views disability as socially constructed; disability is not an individual problem related to a particular diagnosis or impairment, but rather is created from constructed environments that are inaccessible and thus disabling (e.g., buildings without access ramps or elevators) (Dirth & Branscombe, 2017). The pervasiveness of environments' "disabling barriers, attitudes, and cultures" make medical diagnosis and treatment insufficient in supporting people with disabilities (Barnes & Mercer, 2005, p. 5; Dirth & Branscombe, 2017). Therefore, this guide utilizes the definition provided by the United Nations Convention on the Rights of People with Disabilities (2006), which defines disability as any "long term physical, mental, intellectual, or sensory impairment" which interacts with societal and other barriers that limit an individual's full participation (authors' emphasis) in the community" (p. 9). This definition acknowledges that disability is both biological and socially constructed. Victim/survivor service providers have a responsibility to dismantle factors in their own environment that disable those in need of their services.

DEFINING TYPES OF DISABILITIES

Categorization of disability assists practitioners and researchers in understanding both the individual limitations and the societal barriers that individuals and communities experience. However, not all support the categorization of disabilities, which may overlook the social construction of disability (Dirth & Branscombe, 2017).

This guide uses the categories below so practitioners can understand the diversity of disabilities and limitations that come with them. The International Classification of Functioning also uses a social justice framework to illuminate the oppression experienced by people with disabilities (World Health Organization, 2001).

Experiences of disability are diverse both within and across different disabling conditions. This toolkit uses categories of disability defined in the robust National Health Interview Survey: Sensory, movement, emotional, and cognitive disabilities (Altman, 2014).

Sensory disabilities include disabilities which affect the senses, primarily visual impairments and hearing impairments (Altman, 2014). It is important to note, however, that within the Deaf community, deafness is most frequently not considered a disability; Deaf culture is a distinct culture with its own language and customs, hence the capitalization of the word Deaf (Smith & Hope, 2015). Within the Deaf community, some feel that identity-first language (Deaf victim/survivor) is more appropriate than person-first language (victim/survivor who is deaf).

Movement disabilities consist of a wide array of conditions which affect mobility, gross and fine motor skills, and physical endurance (Altman, 2014). These disabilities include conditions such as cerebral palsy, respiratory diseases, and spinal cord injuries, among others.

Emotional disabilities can also be referred to as psychiatric disabilities, mental illnesses, or mental health disabilities. These include disabilities such as schizophrenia and bipolar disorder. In the National Health Interview Survey, emotional disabilities are primarily associated with symptoms of anxiety or depression which cause significant impairment (Altman, 2014). However, psychiatric disabilities encompass conditions that can affect areas of functioning including emotion regulation, executive functioning, social engagement, and energy level, among others.

Cognitive disabilities impact an individual's cognitive functioning, which includes executive functioning (e.g., planning and organization), memory, and concentration (Altman, 2014). Intellectual disabilities, learning disabilities, communication disabilities, and autism spectrum disorder all fall under this category; however, learning and communication difficulties are not well-captured or defined in the National Health Interview Survey (Altman, 2014). Nevertheless, communication disabilities, learning disabilities, and other developmental disabilities are important to consider in the context of sexual violence and IPV, especially in relation to vulnerability to victimization and revictimization and communicating and processing trauma, which will be addressed later in this guide.

PEOPLE WITH DISABILITIES' EXPERIENCES OF VIOLENCE

Risk Factors for Interpersonal Violence

Like students without disabilities, students with disabilities are vulnerable to sexual, physical, emotional, and economic abuse. However, people with disabilities experience certain risk factors for interpersonal violence at higher rates than the general population. Psychological risk factors for abuse such as low self-esteem, feelings of powerlessness, socialized passivity, dependency, and socialization to accept mistreatment more commonly impact people with disabilities than those without (Glover-Graf & Reed, 2006). Often, social isolation, lack of appropriate sexual education, and the perceived asexuality of people with disabilities also increase vulnerability to abuse (Nosek et al., 2001). These risk factors ultimately relate to increased perpetration of interpersonal violence against people with disabilities.

Prevalence of Interpersonal Violence Victimization Among People with Disabilities

Several studies document IPV and sexual violence among people with disabilities. These studies report that people with physical or mental disabilities experienced IPV and sexual violence at higher rates than those without (Martin et al., 2006; Powers et al., 2008; Scherer et al., 2013; Hahn et al., 2014; Breiding & Armour, 2015; Scherer et al., 2016). For example:

- Son and colleagues (2020) found that college students with disabilities experienced higher rates of IPV than students without disabilities (70% compared to 58%, respectively), and this was strongly correlated with higher rates of adverse childhood experiences for students with disabilities.
- Brown et al. (2017) document that women and nonbinary college students with disabilities experienced higher rates of unwanted sexual contact than men and people without disabilities, and women and nonbinary students with autism spectrum disorder were at increased risk compared to those with other disabilities.

- In one study, college students with mental disabilities reported the highest rates of stalking victimization (Reyns & Scherer, 2018).
- Research shows that disparities in experiences of abuse among those with and without disabilities widens as the violence becomes more severe (Brownridge, 2006), and victims/survivors with disabilities experience abuse for longer periods of time than those without (Plummer & Findley, 2012).
- Some studies suggest that people who are at higher risk for abuse include those with voice or speech disabilities, chronic psychosis, and intellectual disabilities (Lin et al., 2010).

It is important to note that the definition of disability varied across these studies. Further research is needed to understand the frequency of violence perpetration against individuals with certain types and severities of disability. Regardless, understanding differences in prevalence of IPV, stalking, and sexual violence for students with disabilities can inform programming on violence prevention and response.

Disability-Specific Violence

It is critical to examine forms of abuse which uniquely impact people with disabilities. For example, students with disabilities may be at risk for abuse by caregivers; isolation and dependence on caregivers increase vulnerability to violence (Nosek et al., 2001; Findley et al., 2016). Caregivers, including paid personal assistants, intimate partners, and family members could threaten to or actually leave the victim/survivor unattended in dangerous situations, damage or withhold assistive equipment, give the wrong dosage of medication, or handle victims/survivors roughly or inappropriately (Nosek et al., 2001; Powers et al., 2008). Financial exploitation by family members, intimate partners, or other caregivers is another abusive, controlling behavior that limits victims'/survivors' access to vital resources. Research by Kutin and colleagues (2017) demonstrated that financial exploitation in the context of intimate relationships is more commonly perpetrated against people with disabilities, especially women. Disability-specific abuse can be physically and psychologically damaging, and often is not defined as a criminal act, which can prevent victims/survivors from seeking legal recourse (Plummer & Findley, 2012). Victims/survivors of abuse with disabilities are also more likely to be disbelieved and perceived as unreliable witnesses, which prolong and exacerbate experiences of abuse (Nosek et al., 2001). These forms of abuse are harmful and more difficult to detect, demonstrating the need for targeted intervention and screening for students with disabilities.

Consent in Disability Communities

The concept of sexual consent is based on 1) a person's developmental capacity to understand sexual activities and their consequences and 2) a person's willingness to perform sexual acts in the absence of coercion (Lyden, 2007). Sexual consent has both legal and social definitions (Indiana Coalition to End Sexual Assault, 2019). Sexual consent capacity and reproductive agency of individuals with intellectual, developmental, and psychiatric disabilities has a complicated history in the United States. In Buck v. Bell, the Supreme Court determined that involuntary sterilization of people with mental disabilities was not only legally permissible, but also preferable to codifying their full reproductive rights (Buck v. Bell, 1927).

This was due to widely-held, inaccurate beliefs about the heritability of mental disabilities and negative societal attitudes about dependence and the parenting abilities of people with mental disabilities (Eisenberg, 2013).

Buck v. Bell was never explicitly overturned, and although the right to privacy has since been invoked by the Supreme Court regarding individuals' sexual and reproductive rights, and state-level standards determining incapacity to make reproductive health decisions have since become much stricter, myths about the sexual, reproductive, and parenting capabilities of individuals with disabilities persist legally and socially (Eisenberg, 2013; Mutcherson, 2017).

Myths surrounding the asexuality, or conversely hypersexuality, of people with mental disabilities are widespread and damaging; lack of appropriate sexual education for individuals with intellectual disabilities is related to significant knowledge deficits and increased vulnerability to abuse and exploitation (Borawska-Charko et al., 2017; Mutcherson, 2017; Monasterio, 2018). Furthermore, adults with disabilities under legal guardianship often lack agency over their sexual and reproductive lives afforded to most other adult members of the population (Indiana Coalition to End Sexual Assault, 2019). Individuals with intellectual and developmental disabilities can acquire skills and knowledge regarding healthy sexual relationships and power dynamics which can lessen vulnerability to coercion and abuse when this education is tailored to their learning needs (Borawska-Charko et al., 2017; Monasterio, 2018). Therefore, simultaneously focusing on empowering individuals with disabilities' healthy sexual expression and reducing vulnerability to abuse is crucial for service providers.

In recent years, many colleges and universities have applied affirmative sexual consent standards to their student conduct policies. These standards typically place more value on verbal, vocal communication (i.e., saying "Yes") than nonverbal communication (e.g., body language) or non-vocal communication (e.g., American Sign Language) and presuppose that communication can be standardized and unambiguous across cultural groups, including those with disabilities (Lockwood Harris, 2018).

Because communication abilities and styles are variable, universities should consider how definitions of sexual consent may unintentionally marginalize and dismiss the sexual agency of students with disabilities.

Ableism and Intersecting Identities

The IPV and sexual violence victims/survivors with disabilities face is compounded with other forms of discrimination. Disability justice advocates define ableism as the "ranking and categorizing bodies and minds as either normative and desirable, or deviant and disposable" (Gibson, 2020, 14:15). Ableist beliefs impact the perceived credibility of victims/survivors with disabilities, including myths that people with disabilities are not sexual beings capable of authentic romantic and sexual relationships or the favorable view of caregivers, even when abuse is expected (Nosek et al., 2001). Ableism intersects with racism, as the bodies of people of color, and Black bodies especially, are historically less valued than White bodies (Gibson, 2020). People with disabilities are objectified because society views their bodies and minds as inferior (Plummer & Findley, 2012). This is layered with objectification that women victims/survivors experience, amplifying its effect on women with disabilities.

Victims/survivors with multiple marginalized identities experience cumulative oppression. For example, communities historically brutalized by law enforcement, such as LGBTQ+ people and people of color, may have an even harder time disclosing their abuse and seeking supportive services (Brubaker et al., 2017). Further, disabilities have historically been criminalized and used as justification to incarcerate Black communities (Gibson, 2020), which may foster greater mistrust among those victims/survivors. Brubaker and colleagues (2017) illustrate barriers in prevention and response related to students who are sexual minorities, racial and ethnic minorities, and international students. They highlight the impact of oppressive systems, including campus police, on how students cope with violence and how violence is measured and responded to in the university context (Brubaker et al., 2017).

Approaches to addressing IPV and sexual violence should consider how identities intersect in experiences of violence and how punitive forms of justice do not always align with the cultural values and experiences of victims/survivors. Additionally, understanding different frameworks of justice and accountability, and their potential impacts on victims/survivors, is crucial, especially when victims/survivors have multiple marginalized identities.

Impacts of Violence

Not only is abuse against people with disabilities often more frequent and complex, but the harmful outcomes are amplified. For example, one study demonstrated that women victims/survivors with a variety of physical, mental, and learning disabilities and men victims/survivors with those disabilities are respectively three and four times more likely to experience depression following abuse than those without disabilities (Scherer et al., 2013). They also experience higher levels of stress from the abuse (Scherer et al., 2013), which leads to increased health risk behaviors, such as binge drinking (Mitra & Mouradian, 2014). Those with disabilities are also more likely to have been sexually abused as children, meaning they are more likely to enter college with complex trauma histories (Alriksson-Schmidt et al., 2010; Mueller-Johnson et al., 2014), which is a strong predictor of sexual victimization in adulthood (Ports et al., 2016). When victims/survivors with disabilities experience violence on campus, it may not be their first experience of abuse, which can worsen the impacts of more recent incidents.

The study included the following disabilities: attention-deficit/hyperactivity disorder, deafness/hard of hearing, learning disability, mobility/dexterity disability, partial sightedness/blindness, psychiatric condition, speech or language disorder, bipolar disorder, obsessive-compulsive disorder, phobia, schizophrenia, or other mental health conditions.

Barriers to Services

Victims/survivors with disabilities may face significant barriers to accessing services, some of which are typical of most victims/survivors. One study found that of students with disabilities who experienced abuse, only 27% sought help (Findley et al., 2016). This is mostly attributed to lack of awareness about resources. The same study found that 40% of people who were abused (both with and without disabilities) said they had little or no information about resources (Findley et al., 2016). Also, all victims/survivors in the study tended to wait several months or longer to report abuse because they did not want to label the experience as IPV or sexual violence, or because they did not think it was severe enough to warrant help (Nichols et al., 2018).

There are several other barriers to accessing help that are specifc to students with disabilities. Victims/survivors with disabilities may be physically, emotionally, and/or financially dependent on their abuser, especially if the abuser provides care, and reporting and escaping the abuse may lead to the loss of a significant caregiver (Plummer & Findley, 2012; Fraser-Barbour, 2018). Further, because those with disabilities are devalued due to their disability, discrimination may lead to low self-esteem and body image, making them feel that the abuse is their fault or deserved (Plummer & Findley, 2012). Isolation occurs in many abusive relationships but puts those with disabilities at particular risk. For example, those with disabilities who were less mobile and more socially isolated had a higher likelihood of experiencing abuse (Plummer & Findley, 2012). Isolation for those with disabilities also includes restricting use of communication devices, which prevents victims from responding to and reporting abuse (Plummer & Findley, 2012).

There are additional systemic barriers to reporting for victims/survivors with disabilities. Resources, such as domestic violence shelters, may not accommodate their disability due to lack of ADA compliance (Plummer & Findley, 2012). There is also lack of coordination to obtain necessary services, such as personal care services and sign language interpreters (Plummer & Findley, 2012). These systemic issues delay establishing physical safety and the reporting and investigation processes.

Many universities have not begun to address ableism at the institutional level or among individual faculty and staff. Therefore, many colleges and universities are currently ill-equipped to appropriately accommodate students at the intersection of disability and victimization. For example, professors may be reluctant to adhere to students' accommodations from Title IX if they already perceive students' disability accommodations to be cumbersome or unnecessary (Shetler, 2020). Students' fear of stigma and faculty members' lack of willingness to adhere to disability accommodations are common among students with invisible disabilities, including psychiatric disabilities, acquired brain injury, and learning disabilities (Denhart, 2008; Bahraini, 2018). It is therefore critical to provide additional support and advocacy to students with invisible disabilities who experience victimization during their college careers.

Universities that are successful at combatting ableism acknowledge that higher educational institutions are spaces founded on ableism, privilege, and oppression. These universities acknowledge their historical roles in contributing to environments that disable students by not accommodating their unique needs and actively work toward normalizing and accommodating such needs. Ensuring faculty and staff are trained regarding diverse student needs is a small step which places the responsibility on the university to be more meaningfully inclusive rather than requiring students with disabilities to assimilate into a space that was not built for them in the first place. This also means that institutions that address ableism not only cultivate faculty and staff buy-in regarding flexibility in teaching style; it also means that they hold faculty accountable when they violate institutional aims of inclusion.

RECOMMENDATIONS

This guide makes the following recommendations to support the safety of intimate partner violence (IPV) and sexual violence victims/survivors with disabilities on college campuses. When adopting and implementing these interventions, institutions of higher education should embrace having students with disabilities actively involved in the planning process, so they can inform how these services will best benefit them. These recommendations are based on best practices and most current research evidence.

Recommendation 1: Train service providers on violence against students with disabilities

This guide has identified that violence against those with disabilities may differ from violence against those without, including types of abuse and impact of the abuse. Therefore, those who serve victims/survivors of IPV and sexual violence are not fully prepared unless they are trained to respond to the needs of victims/survivors with disabilities (Martin et al., 2006; Fraser-Barbour, 2018). This training should include how intersecting identities, such as gender, race/ethnicity, and sexual orientation impact victims/survivors with disabilities' experiences. All trainings should integrate the needs of diverse victims/survivors with disabilities, rather than taking a blanket approach to IPV and sexual violence services (Linder, 2018).

Universities should also ensure that staff in disability services offices are prepared to respond to IPV and sexual violence the students they serve may experience (National Council on Disability, 2018). Training should incorporate types of violence, available resources, and an intersectional framework.

Recommendation 2: Share information with students with disabilities

Students with disabilities may have challenges accessing and interpreting information about IPV and sexual violence. Further, many of these students will enter college with abuse histories, so they would especially benefit from targeted outreach (Findley et al., 2016). Universities should tailor their outreach materials to reach students with disabilities. Universities can improve the accessibility of information by using different mediums of communication, including instructional video modeling, social stories, comic strips, and other visual tools (Fraser-Barbour, 2018). Universities should include specific information and resources for students with disabilities and how to access these services (Findley et al., 2016). Materials should use plain language to ensure they are understandable to all students and should include images of students with disabilities to demonstrate the diversity of students providers are prepared to serve. Victim/survivor service providers and disability services office staff should work together on producing these resources. Students should be made aware of available resources via course syllabi, in academic and recreational buildings on campus, and social media platforms.

Recommendation 3: Increase accessibility of victim/survivor services

Victims/survivors with disabilities may have difficulty accessing certain resources if victim/survivor service providers do not consider their physical and psychological limitations. Victim/survivor service providers need to make sure programs are accessible (Martin et al., 2006). This may include using alternate communication methods, such as sign language interpreters, and having different ways to physically access victim/survivor service buildings. If victim/survivor service offices are not accessible, providers should proactively work with students and disability services staff to provide accommodations.

Service providers must ensure that crisis hotlines are available to all students with disabilities. They must establish procedures to respond to students with disabilities, including students with sensory disabilities, especially Deaf and hard-of hearing students (National Council on Disability, 2018). This includes offering text lines and advertising their accessibility. Additionally, all first responders, such as victim advocates, university police, and EMTs, must have access to emergency interpreter services to ensure clear, prompt communication while students are in crisis (National Council on Disability, 2018). Further, service providers must have clinicians trained in therapeutic interventions that are accessible to students with disabilities.

Recommendation 4: Discuss abuse against students with disabilities in prevention programming

In any IPV and sexual violence prevention and bystander intervention program, the curriculum should include perspectives of students with disabilities (National Council on Disability, 2018). This includes teaching all students, faculty, and staff the forms of IPV and sexual violence that are unique to, or more extreme for, students with disabilities. Programming should incorporate resources specific to students with disabilities and address any accommodations available related to their accessibility. At least one scenario about IPV and sexual violence should incorporate a victim/survivor with a disability (Shetler, 2020). Again, victim/survivor service providers and disability services office staff should work together on producing these resources.

Additionally, this programming should reach faculty and staff who will interact with students with disabilities. Faculty and staff should be aware of accommodations these students will need and how failing to make these accommodations is a manifestation of ableism and discrimination. This training should include the intersection of racism, sexism, and ableism, in order to fully articulate the ways these systems harm students with disabilities who experience violence.

Recommendation 5: Integrate disability services with IPV and sexual violence services

In prevention and response efforts, universities should follow a whole-school approach, meaning that all members of the university community, including leadership, staff, faculty, and students, should invest in responding to the needs of victims/survivors of IPV and sexual violence (McMahon et al., 2019). This is especially true for students with disabilities, as they may require unique services.

For example, victims/survivors with disabilities may encounter a variety of different services, such as mental healthcare and other healthcare services, in addition to victim/survivor service providers. These victims/survivors would benefit from coordinated services to increase access points (Nichols et al., 2018). Integration will also help victim/survivor service providers become more sensitive to the needs of students with disabilities (Plummer & Findley, 2012). One way to integrate these services is having healthcare providers screen for IPV and sexual abuse and then connecting patients with resources (Martin et al., 2006; Basile et al., 2016). When screening for abuse, healthcare providers should (Curry et al., 2008):

- Offer support to the person completing the screening tool, such as reading and clarifying questions.
- Administer the screening tool while the victim/survivor is alone. Do not allow anyone to accompany them, including a personal assistant, as they may be abusive. Be aware this may elicit anger.
- Take breaks during the screening to check in with the client.
- Offer supports, resources, and referrals, regardless of the client's answers to the screening questions, and encourage them to share those resources with others.

While collaboration between disability services, health care providers, and victim/survivor service providers is essential to providing comprehensive care, no provider should assume a victim/survivors' disability, or disclose that disability to any of these partners without their permission (Shetler, 2020).

Recommendation 6: Amplify the voices of students with disabilities in sexual assault and IPV prevention and response

For the last three decades, educators and researchers have advocated for including students in shaping institutional policy to promote genuine inclusivity, democratic participation, and school responsiveness (Bahou, 2011; Lac & Cummings Mansfield, 2018). Institutions of higher education historically and currently marginalize students with disabilities through ableism in academia (Carroll et al., 2020). Student voice has been used to shape policy around mental health (Squires, 2019), disability (Gordon, 2010), LGBTQ+ identity (McLaughlin, 2017), and student experiences of minoritization (Cheung et al., 2019).

Whole school approaches to violence prevention and response similarly use student participation and activism both because sustainable violence prevention and response occurs at various socio-ecological levels and because student input is crucial in institutional policy regarding campus violence (McMahon et al., 2019). Therefore, the voices of students with disabilities should inform sexual assault and IPV prevention and response to address current service gaps and oversights. This should involve university definitions of consent that are inclusive to students with disabilities.

Conclusion

Universities can leverage their existing resources to better support victims/survivors with disabilities. However, some additional investments may be necessary to provide students with disabilities the safe educational experience they deserve.

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