

Applying the Social Ecological Model to Violence against Women with Disabilities

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Abstract

Violence against women (VAW) is a broad term used to capture aggressive acts committed toward women, which consists of numerous types of violence with the most commonly known types of abuse being emotional, sexual, and physical. One relatively invisible group, women with disabilities, not only experiences emotional, sexual, and physical abuse but also a unique type of disability-related abuse, which may increase their risk of experiencing acts of violence. The U.S. Congress passed two distinct yet not mutually exclusive policies into law to address violence against women and rights for individuals with disabilities: the Violence against Women Act and the Americans with Disabilities Act. This paper will discuss these policies with suggestions to increase protection for women with disabilities experiencing violence and the implications for these policy changes using the social ecological model.

Keywords: Violence against women; Health; Women with disabilities; Americans with disabilities act; Social ecological model; Violence against women act

Introduction

Violence against women is a worldwide social phenomenon, considered an epidemic by the World Health Organization (WHO), affecting an estimated 33% of women [1]. The United Nations (U.N.) estimates that “up to 70 percent of women and girls will be beaten, coerced into sex, or otherwise abused in their lifetime” [2]. Violence against women (VAW) is a broad term used to capture aggressive acts committed toward women. In the United States (U.S.), VAW affects 1 in 4 women. According to Allsworth et al., “Approximately 25% of women have experienced some type of physical, sexual, or emotional violence during their lifetime, and nearly two thirds of this violence is perpetrated by current or former partners” [3]. Violence against women committed by current or former romantic partners is known in the literature as intimate partner violence, also known as domestic violence [4]. Literature shows that women with disabilities were more likely to be abused by a greater number of perpetrators compared to women without disabilities [5]. Therefore, a more appropriate term to describe the type of violence women with disabilities encounter is interpersonal violence, which encompasses the violence that occurs between family members and intimate partners and violence between acquaintances and strangers [6].

The topic of abuse and violence is highly ranked as a concern among women with disabilities [4]. Women with disabilities are more vulnerable to abuse [7], with a 40% greater risk of violence than women without disabilities [8]. Yet they remain an understudied subset of the population. As a relatively invisible group, women with disabilities, not only experience commonly known types of violence but also disability-related abuse [9].

Theoretical framework

Theoretical explanations shed light on the phenomenon of VAW. According to Jasinski, “By understanding some of the risk factors or causes of violence against women, more effective prevention and intervention programs can be developed” [10]. There are numerous theoretical explanations for VAW ranging from macro-level theories, which include sociocultural explanations, and micro-level theories, which include intra-individual and social psychological explanations [11]. Theories that incorporate both macro- and micro-level aspects are known as multidimensional theories [10]. This research project

examined VAW within a social ecological model, which falls under the multidimensional theory definition as it combines both macro- and micro-level aspects. For this project, the social ecological model levels consisted of the following levels: society (United States), policy (Americans with Disabilities Act (ADA) and Violence against Women Act (VAWA)), community (resources/environment), interpersonal (relationships), and individual (intrapersonal) (Figure 1).

Bronfenbrenner created the ecological model as a new way of examining human development; looking at the developing person, the environment, and the interaction between the two [11]. The metaphor offered by Bronfenbrenner (1979) illustrates the interplay between all of the levels of the social ecological model, as the figure above attempts to do as well, “The ecological environment is conceived as a set of nested structures, each inside the next, like a set of Russian dolls” (p. 2) [11]. Continuing on with Bronfenbrenner’s original model Sallis and colleagues go on to explain that a strength of examining multiple levels of influence through social ecological models is that “Ecological models can incorporate constructs from models that focus on psychological, social, and organizational levels of influence to provide a comprehensive framework for integrating multiple theories, along with consideration of environments and policy in the broader community” [12]. For example, the Americans with Disabilities Act states all abuse-related resources should be accessible to women with disabilities. The influence of the ADA on the accessibility of abuse-related resources is included within a social ecological model; whereas, this factor is not taken into consideration within other theories.

The social ecological model is tailored to show that the different levels are constantly interacting to influence violence against women. This model has four core principles:

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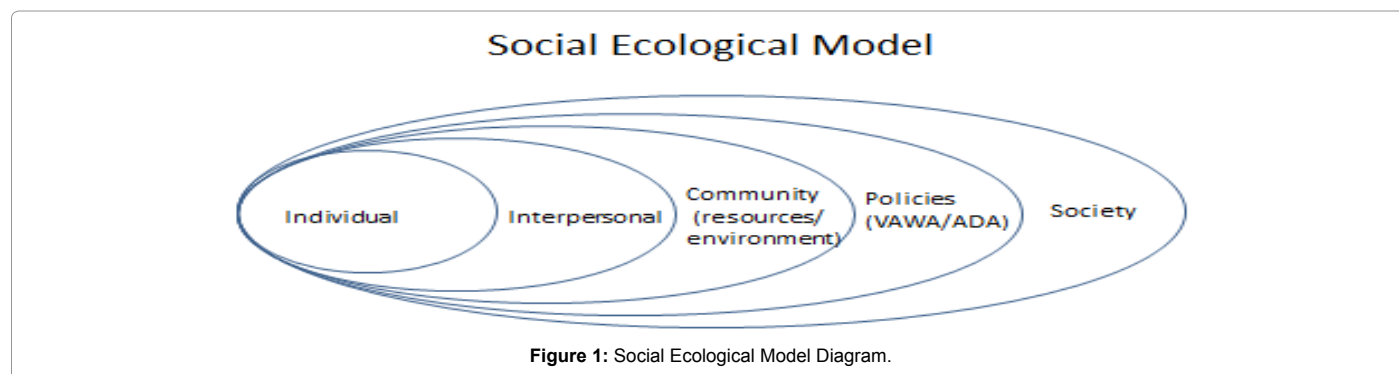


Figure 1: Social Ecological Model Diagram.

“(1) There are multiple influences on specific health behaviors, including factors at the intrapersonal, interpersonal, organizational, community, and public policy levels; (2) Influences on behaviors interact across these different levels; (3) Ecological models should be behavior-specific, identifying the most relevant potential influences at each level; and (4) Multi-level interventions should be most effective in changing behavior” [12].

Since the social ecological model can be tailored, numerous researchers have used the social ecological model to try to better understand violence against women. For example, White proposed gender be at the center of her social ecological model and social identity as a meta-construct since identity is influenced by all levels [13]. The other levels in her social ecological model: individual (intrapersonal), assault, microsystem (interpersonal), meso/exosystem (social networks/ community), macrosystem (society), and chronosystem, which is defined as “...the ongoing changes and cumulative effects that occur over time as persons and their multiple environments interact” [13]. Three of the four principles have been met by White, the fourth principle was not the focus of the article; thus, interventions were not addressed [13].

The additional components proposed by White may bring complications to an already complex health behavior [13]. Strength of the social ecological model is that it allows for an integration of theories. Both gender and identity formations are characteristics at the individual-level, which is affected by all the other levels. Therefore, adding these components should be avoided and instead a theory incorporating these components at the individual level should be considered. Since one of the basic assumptions of the model is that all levels are constantly interacting then it is understood that individual characteristics will be affected; thus, choosing the correct theory for the individual level is the issue instead of adding additional levels to an already level-heavy model.

White examined adolescent dating violence, continuing with a subgroup of this age group, Banyard and Cross focused specifically on teen dating violence [13,14]. A strength of the White study was the focus on all levels of the social ecological model; whereas, Banyard and Cross only focused on the intrapersonal and interpersonal levels [13,14]. The interpersonal level focused on the relationship and social supports. A limitation of both studies is the focus on physical and sexual abuse only leaving emotional abuse unexamined. Banyard and Cross (2008) did a cross-sectional study examining the negative mental health and educational outcomes among teens in 7th through 12th grade who experienced dating violence with a convenience sample of 2,101 participants with 51% being female. Dating violence was found to be “associated with higher levels of depression, suicidal thoughts, and poorer educational outcomes,” such as dropping out of school, while

identifying social support from parents and community as potential protective factors, more so, for girls [14]. One limitation of this study is it was a cross-sectional study. This type of study can show correlations and associations between abuse and negative mental health and educational outcomes but cannot prove causation. Another limitation was the lack of examining all levels of the social ecological model such as school policies on teen dating violence. Another potential limitation was including social support from parents and community in the interpersonal level instead of its own level since these aspects would have their own unique impact on the teen’s relationship; thus, should be examined separately.

Shifting from adolescent and teen violence to interpersonal violence, Sitaker met all four core principles of the social ecological model with four levels: individual, interpersonal, community, and cultural context [15]. Unlike White who proposed assault as a separate level, Sitaker does not, instead the interpersonal level contains the abusive relationship and family and friends, similar to Banyard and Cross [13-15]. Community is the next level which contains the institutions and social structures in the community. Sitaker included social networks and peer groups in this level [15]. The placing of social networks in this level may be understandable since these networks would have influence on the abusive relationship but one could question the decision to separate family and friends from social networks at the community-level, when family and friends are considered an individual’s social network, instead family and friends were included in the interpersonal level. The definition of social network was not provided, which is important for future studies to determine which level to be placed for intervention purposes; yet, later, Sitaker mentions social supports, not social networks, appear to be a protective factor [15]. These two terms appear to be used interchangeably but are different. Social networks can be defined as “...the web of social relationships that surround individuals,” which social support may or may not be provided by the members of one’s social network [16]. Social support can be defined as “aid and assistance exchanged through social relationships and interpersonal transactions” [16]. The fourth, and final, level of Sitaker’s social ecological model is cultural context. This level contains “the economic and social environment, representing the general views and attitudes that permeate the culture at large” [15]. These discussion points, however, are inappropriately elaborated on under the community level such as male dominance and masculine ideology.

Up to this point, the literature reviewed did not include violence against women with disabilities. This relatively invisible group of women not only experiences the same types of abuse as women without disabilities but also disability-related abuse, which increases their risk for abuse [9]. One major change to the social ecological model occurs when women with disabilities are included, and that is the addition

of an environmental level [17]. This level includes the accessibility of community resources to leave abusive relationships, such as domestic violence shelters. The inaccessibility of these resources has been identified as a barrier for women with disabilities [17].

The society (similar to Sitaker's cultural) level is expanded as well when women with disabilities are included in the public health issue of violence against women. The way society views women with disabilities increase their vulnerability to abuse [17,18]. For example, "because women with disabilities are stereotyped as passive, asexual, and dependent, they have been stripped of traditional female roles such as caregiver, mother, and wife" [17]. This view of women with disabilities as asexual may result in a "lack of education about appropriate sexual behavior," which can increase the women's vulnerability to sexual abuse. If women with disabilities are not provided education about inappropriate and/or abusive behaviors, then they will not label the behaviors as such [17]. This example shows the direct influence of society's perceptions of women with disabilities on them at the individual-level through the social ecological model framework.

The labeling of experiences as abuse is associated with issues in determining the prevalence of abuse at the society-level and help-seeking behaviors at the individual-level. Women may not use the term "abuse" due to the negative perception and stigma of the word itself carries. This is one reason why some abuse screening tools list behaviors instead of directly asking, "Have you ever been abused?" While a woman may not label or recognize she is in an abusive relationship, she may experience adverse health implications, which may cause her to seek assistance from a health care provider for the health condition not abuse; therefore, it is important for healthcare providers to recognize signs of abuse and to screen all women for abuse. This is an especially important aspect to look at among women with disabilities as health care providers may attribute the woman's physical and mental health statuses on her disability instead of a sign of abuse [7]. This represents the influence of society on the policy-level which in turn affects the individual-level.

While most studies using SEM do not focus on all levels, this paper will further elaborate on the interactions between all levels of the SEM. For example, literature reviews show that women in abusive relationships have adverse health effects due to being in an abusive relationship, the individuals operating community resources should respond by looking for these health consequences as signs of abuse; thus, affecting their policies. These policy changes should be shared with other organizations creating additional policy changes and educational tools to help society at large identify abuse. This is ideally how the SEM would work; yet, even though this information is available, the U.S. policies have not been modified to accommodate women with disabilities in abusive relationships. Each level of the SEM will be discussed in further detail with implications for applying the SEM to the topic of violence against women with disabilities.

Society

American society's perception of women with disabilities views having a disability as a protective factor that would protect women from abuse; yet, this is quite the opposite, as having a disability is a risk factor for abuse [7]. Nosek et al. states, "The reaction of the general public, medical professionals, and disability-related service providers to information about abuse of women with disabilities is often one of shock and disbelief, as if they believe that disability is somehow a protective factor against this epidemic social problem" [7].

Women with disabilities have an increased vulnerability to sexual

abuse based on the stereotypes of them being "asexual, childlike and dependent or oversexed, undiscriminating and "easy"" [19]. These stereotypes have had devastating effects in the past for people with disabilities by infringing on their reproductive rights, especially among women with disabilities. The rise of the Eugenics Movement in the late nineteenth century sparked these inaccurate stereotypes of women with disabilities that still reverberate to this day [19]. The main premise of the Eugenics Movement was to control who may reproduce in order to improve the human race as it was believed heredity was responsible for disabilities. The Eugenics Movement painted women with disabilities as "unfit for procreation and as incompetent mothers". This line of thought has attributed to other stereotypes as women with disabilities being dependent and asexual, which are still present to this day [20]. During the Eugenics Movement, these ideas provided the groundwork to take away their reproductive rights by involuntarily sterilizing thousands of women with disabilities to prevent the spread of disabilities. Even though involuntary sterilization is now illegal, some women with disabilities are still subjected to having their reproductive rights violated by being provided birth control without their knowledge or without informed consent as to the purpose of the medication which is still reminiscent of the Eugenics Movement [19]. Another issue with these inaccurate stereotypes results in denying one's sexuality; thus, not providing the proper education about appropriate and inappropriate sexual boundaries which may increase the vulnerability of abuse among women with disabilities. This vulnerability requires further investigation as one reported prevalence rate of sexual abuse among women with developmental disabilities is as high as 70% [19].

"Some people think abusive treatment is necessary to manage people with disabilities or blame disabled victims for the abuse they suffer, and because they hold these beliefs they consider domestic violence against people with disabilities to be justified" (NCADV, n.d.). Therefore, it is of major importance to educate society about people with disabilities in order to change misconceptions such as these. Education is a powerful tool and will be needed in order to help eliminate violence against people with disabilities.

Policy

The U.S. Congress passed two distinct yet not mutually exclusive policies into law to address violence against women and rights for individuals with disabilities: the Violence Against Women Act and the Americans with Disabilities Act (ADA, 1990) [21]. These policies, following the foundation laid by the civil rights and feminist movement, addressed issues relating to violence against women and people with disabilities as human rights violations, impeding on the right to participate fully in society. This section of the paper discusses these policies and offer suggestions to increase protection for women with disabilities experiencing violence. Violence against women is a relatively recent concern for social scientists, activists, and legislators and has only been considered a serious social problem since the late 1960s and early 1970s Jasinski, when the extent of interpersonal violence (IPV) was uncovered by the Battered Women's Movement (Tierney, 1982) [9,22].

The United States Congress responded to the increased awareness of VAW as a significant social problem by passing comprehensive landmark legislation, the Violence Against Women Act (1994) (Meyer-Emerick, 2002), which was Title IV of the Violent Crime Control and Law Enforcement Act [21,23]. Sexual assault was the main focus of the VAWA, calling for federal penalties for sex crimes and providing new evidentiary rules for alleged sexual misconduct. A strength of the VAWA, Subtitle B: "Safe Homes for Women" was that funds were

specifically provided to begin operation of the National Domestic Violence Hotline. This subtitle also implemented mandatory arrest in domestic violence calls, as well as provided harsher punishments for those who crossed state lines to harm their intimate partner, which included emotionally abusive acts such as harassment, intimidation, coercion, and duress, and physically abusive acts such as injury. This is called Interstate Enforcement. While some individuals consider these punitive measures strengths of the VAWA, others consider them shortcomings, potentially placing victims in more danger because the abuse may get worse upon the abuser's release from jail due to anger about being arrested [24]. Another shortcoming of the VAWA identified is the lack of consistent definitions of violence against women which have negative impacts of the resources victims have access [24].

The original VAWA did not exclude women with disabilities, but it also did not specifically target them as a population vulnerable to violence. The U.N. resolution 48/104 Declaration on the Elimination of Violence Against Women did voice concern that some groups of women, such as women with disabilities, were more vulnerable to violence [20]. Despite the U.N. resolution, which followed the U.N.'s "Decade of Disabled Persons," which began in 1983, and the passage of the Americans with Disabilities Act, the VAWA did not mention or provide funding for services directed toward women with disabilities [25,26]. The latter did not occur until the 2000 Reauthorization of the VAWA. This may be due to American society's perception of women with disabilities, which views having a disability as a protective factor that would protect women from abuse [8]. The VAWA should take into consideration disability-related abuse and put resources in place to assist women with disabilities experiencing abuse.

While the VAWA and ADA are policy efforts in the United States to eliminate violence against women with disabilities, the World Health Organization (WHO), which is a specialized agency of the United Nations, are making efforts at the international level. The United Nations efforts to decrease violence against women internationally must be acknowledged as an influence to reducing violence against women in the United States. These efforts should continue to be incorporated into policies created by the United States government with the goal to eliminate violence against women.

The United Nations created three mandates in an effort to decrease violence against women internationally. As a way to address the three mandates, the WHO conducted a multi-country study on women's health and domestic violence with the data being collected between the years of 2000 and 2003 in ten countries: Bangladesh, Brazil, Peru, Thailand, United Republic of Tanzania, Ethiopia, Japan, Namibia, Serbia, and Montenegro. The first of the three mandates of the United Nations in an effort to decrease violence against women internationally is, "To collect information on violence against women and its causes and consequences from sources such as Governments, treaty bodies, specialized agencies and intergovernmental and non-governmental organizations, and to respond effectively to such information".

A study addressing the consequences of abuse mentioned in UN's first mandate, Ellsberg et al. found significant associations between IPV and self-reported poor health [27]. This finding is supported by numerous studies conducted in the United States that found IPV has been associated with adverse health implications - such as worse physical (e.g., headaches) and mental (e.g., depression) health statuses than women who have not experienced violence [6,28-31]. Other adverse health implication associated with IPV are sexual transmitted infections (STIs) and cervical cancer as well as multiple other health implications such as, depression, substance abuse, smoking, pregnancy,

and sexual risk behaviors [29]. These findings are true for both women with and without disabilities; yet, most resources only go to assist women without disabilities. These findings show the importance of eliminating violence against all women; in addition, show a dire need to remedy the consequences of violence.

The second mandate is, "To recommend measures and ways and means, at the national, regional, and international levels, to eliminate violence against women and its causes, and to remedy its consequences" [32]. Addressing the second UN mandate, Abramsky and colleagues found three protective factors from interpersonal violence: secondary education, high socioeconomic status, and formal marriage and several risk factors [33]. The risk factors are significant as they offer a key at helping to eliminate one aspect of violence against women, namely interpersonal violence. These risk factors are: "alcohol abuse, cohabitation, young age, attitudes supportive of wife beating, having outside sexual partners, experiencing childhood abuse, growing up with domestic violence, and experiencing or perpetrating other forms of violence in adulthood, increased the risk of IPV" (p. 1). These risk factors are similar to studies conducted in the United States which suggest that the real solution to eliminating IPV is by addressing these risk factors, which would include alcohol treatment, therapy, and counseling [23]. Not including treatment options such as these for the perpetrator in the VAWA is a criticism of the US policy.

The United States is considered a pioneer for its policies on violence against women [34]. However, there is much work to be done in order to eliminate violence against a subset of the population that the Violence Against Women Act (VAWA) targets, women with disabilities. While the Americans with Disabilities Act (ADA) offers guidelines to make services available to women with disabilities, the lack of enforcement is an issue, in addition to the lack of education to make services, such as domestic violence services, accessible to women with disabilities.

Community (resources/environment)

Help-seeking behaviors: Women's knowledge of available abuse-related resources in the local area at the community-level should be increased to assist with the utilization of such services when they are in need. Examples of these types of resources are medical and legal services, such as emergency rooms and restraining orders, respectively. However, accessing these resources to escape IPV may depend on the type and severity of abuse. Women of IPV who experienced sexual abuse were 1.3 times more likely to seek medical care compared to women who experience emotional abuse only; whereas, women who experienced physical abuse or sexual abuse sought legal services 3.2 times and 1.6 times more, respectively [35]. Women of IPV experiencing emotional abuse were least likely to seek medical and legal services until it became severe which is a cause for concern. As best stated by an informant in Johnson's (2008) book, "A Typology of Domestic Violence," noting that verbal abuse is used interchangeably with emotional abuse,

"I used to say I found the *verbal* abuse much worse than the physical abuse. Even though the physical abuse was terrible. Because I suppose it was only - only!? God - once, twice a year. It was the constant verbal [attacks] that used to get me down more than anything. Cause *that's* how you lose your self-esteem. But the violence is awful, the violence is terrible. I think you've got to take that, though, as part of it. If you're constantly being told you are a useless jerk, to be [beaten] just... compounds it" [36].

This example is powerful because the informant discusses the

consequences of emotional abuse such as loss of self-esteem along with her opinion that this type of abuse was worse than the physical abuse; yet, women of IPV who experience physical abuse are more likely to seek medical and legal services than those experiencing emotional abuse. This is an important aspect to explore in order to increase utilization of help services by women experiencing emotional abuse.

In a study conducted in a health care clinic by Gillum, Sun, and Woods, women who screened positive for IPV that received brochures containing health information and a list of community resources along with a monthly phone call regarding contact information were significantly less likely to engage in safety-promoting behaviors compared to women who received an on-site counseling session and six follow-up counseling sessions over the phone [37]. This finding suggests the usefulness of screening for IPV in health care clinics and well as intervening with counseling if screened positive for IPV [37].

Accessibility of community resources: Another factor increasing the vulnerability of women with disabilities to abusive relationships is the inability to leave the abusive relationship as the community resources are not accessible. Access has been a critical issue for people with disabilities. Another aspect the U.N. focused on was "...to provide access to just and effective remedies and specialized, including medical, assistance to victims..." (OHCHR, 2012) [38]. This implies a call to action to provide the specialized assistance women with disabilities in abusive relationships need. Yet, this has not been the case for women with disabilities in the U.S., even though the 2000 and 2005 Reauthorizations of the VAWA specifically appropriated funding to increase access to this population. Architectural inaccessibility of community resources or inability to accommodate women with disabilities has been identified as a barrier for women with physical disabilities to escape abusive relationships [8,38]. This is one of the intervention points for the ADA to help protect women with disabilities, as domestic violence shelters must be in compliance, but the lack of enforcement adds to the vulnerability of this population. Access to community resources such as domestic violence shelters is a right for women with disabilities currently supported under the Americans with Disabilities Act (ADA).

The ADA was passed in 1990 to protect individuals with disabilities against discrimination. There are five titles which cover specific areas. Abuse-related community resources must comply with either Title II: State and Local Government Activities including Public Transportation or Title III: Public Accommodations, depending on the type of funding received. Community resources that receive funding from the United States Federal Government must adhere to the guidelines laid out under ADA Title II. Shelters that are not-for-profit and/or privately owned must follow the guidelines under ADA Title III. The ADA not only addresses physical access of buildings but also for "reasonable accommodations" to be made to access services, including but not limited to having a sign language interpreter available, print resources available in alternative formats, such as large print and braille, and making exception to allow service dogs and personal assistants.

Interpersonal (relationships): According to Allsworth et al., "Approximately 25% of women have experienced some type of physical, sexual, or emotional violence during their lifetime, and nearly two thirds of this violence is perpetrated by current or former partners" [3]. Women with disabilities experience abuse at rates similar to, if not higher than, women in the general population [40]. Women with disabilities are more vulnerable to abuse [6], with a 40% greater risk of violence than women without disabilities [7].

One reason why women with disabilities experiencing abuse do

not seek help services may be a lack of identifying their experience as abusive, which could be due to a lack of education or because the woman is unaware of her situation. As pointed out by Mies, "only when there is a rupture in the 'normal' life of a woman, i.e., a crisis such as divorce, the end of a relationship, etc., is there a chance for her to become conscious of her true condition" [41]. Meaning that while the woman is in an abusive relationship she may fail to realize it is abusive until something happens, may be like reading a pamphlet containing abuse screening questions, a list of abuse-related resources available in the area, or being screened for abuse by a doctor.

According to the Feminist Majority Foundation, "IPV accounts for as many as half of 911 calls, and battered women account for 15-30% of emergency rooms visits" [42]. The cost of interpersonal violence to the U.S. health care system and employers was estimated to be more than \$8.3 billion in 2003, by the CDC [43]. These numbers provide supporting evidence to the importance of ending violence against women. This is an important aspect to look at among women with disabilities as health care providers may attribute the woman's physical and mental health statuses on her disability instead of a sign of abuse [8].

Individual (intrapersonal): Disability is defined by the Americans with Disabilities Act (ADA) Amendments Act of 2008, as "a person who has a physical or mental impairment that substantially limits one or more major life activities of such individual, a record of such an impairment, or being regarded as having such an impairment" [44]. Major life activities include both activities of daily living (e.g., mobility, eating) and instrumental activities of daily living (e.g., balancing a checkbook, grocery shopping). People with disabilities are one of the world's largest minority groups, numbering between 650 million and 1 billion people. There are approximately 54.4 million people with disabilities, which make up 19% of the population, in the United States (U.S. Census Bureau, 2008) and "it is estimated that 26 million American women, or nearly 20% of the population of women, live with a physical disability" [6,45,46]. Women with disabilities represent 4% of the U.S. population between ages 5-15, 11% between ages 16-64, and 42% age 65 and older.

One factor at the individual level that increases the vulnerability of women with disabilities to abuse is employment. Lack of economic independence has been identified as a reason women with disabilities are at an increased risk of experiencing abuse [6]. Employment can provide the following benefits: health insurance, increase self-worth, social support (co-workers), funds to leave relationship, and access to resources such as therapy, counseling, and other community resources. Unfortunately, women with disabilities are less likely to be employed. Only 16.5% of women with disabilities aged 16-years-old and older are in the workforce compared to 54.4% women without disabilities, which is approximately a 38% difference. In comparing the unemployment rate between these two groups, 13.8% women with disabilities versus 8.1% women without disabilities. These two figures represent the economic disadvantage of women with disabilities. Further, the U.S. Census Bureau breakdown poverty status for individuals with disabilities aged 25- to 64-years old: 27.1% of individuals with severe disabilities, 12% of individuals with non-severe disabilities compared to 9.1% of individuals without disabilities live in poverty [42]. With these numbers, it is no wonder lack of economic independence was determined to be a critical risk factor [6].

Conclusion

The Russian doll metaphor offered by Bronfenbrenner illustrates

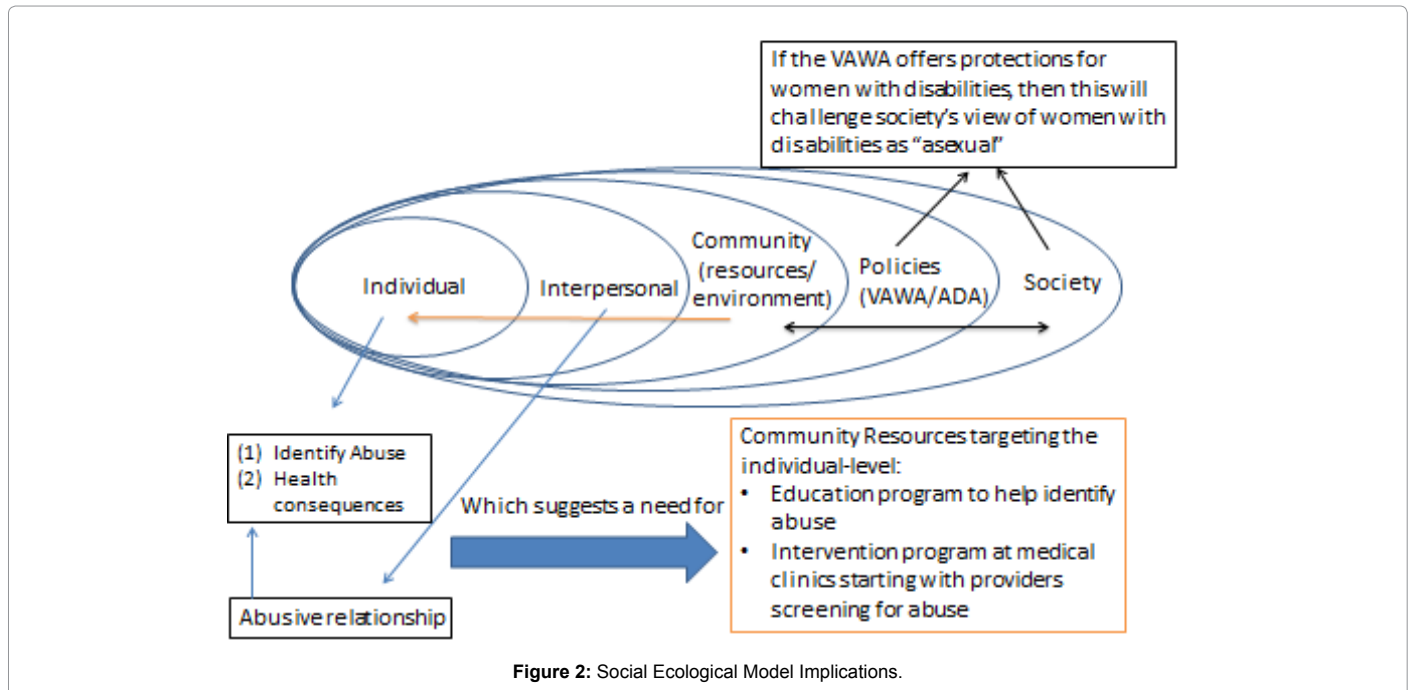


Figure 2: Social Ecological Model Implications.

the interplay between all of the levels of the social ecological model. Therefore, you cannot implement a program at one level without impacting the other levels. For example, strengthening the protections offered to women with disabilities under the VAWA policy will challenge the stereotypes at the society-level as well as require resources at the community-level to be available to women with disabilities who are in abusive interpersonal relationships and may be experiencing health consequences from being in an abusive relationship (Figure 2).

In conclusion, American society's perceptions of women with disabilities view having a disability as a protective factor from abuse, but studies have found that women with disabilities experience abuse at similar or increased rates of abuse as women without disabilities. Society's perceptions of women with disabilities being "asexual, childlike, and dependent or oversexed, undiscriminating, and "easy" need to be challenged as well, as these views may hinder someone from recognizing women with disabilities are in abusive relationships.

The Reauthorization of the Violence Against Women Act (VAWA) on February 28, 2013, provided resources for additional subgroups of women: Native American, immigrant, and lesbian, gay, bisexual, and transgender (LGBT) however, women with disabilities is still a missing subgroup to be given resources under the VAWA [47]. The Violence Against Women Act (VAWA) and the Americans with Disabilities Act (ADA) policies should work together in order to adequately protect those individuals with disabilities who are in abusive relationships, including but not limited to expanding definitions of abuse to include disability-related abuse and the accessibility of community resources, which may include allowing or accommodating those with personal assistants, communication devices, and other assistive technologies.

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