DISABILITIES/DIFFERING ABILITIES AND TRAUMA

Under the Americans With Disabilities Act, an individual is considered to have a “disability” if she or he has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. Examples offered by ADA of major life activities include seeing, hearing, speaking, walking, breathing, performing manual tasks, learning, caring for oneself, and working (US EEOC, 2002). Disabilities that fall under this definition range widely, from sensory or physical (such as conditions impacting vision or hearing or mobility) to psychiatric (such as depression or schizophrenia), cognitive (such as Alzheimer’s or dementia) and developmental (such as Down Syndrome, autism or fetal alcohol spectrum disorder).

In contrast to the medical model of disability, which focuses on individual “deficits,” is the social model of disability. The social model of disability identifies systemic barriers – inaccessible buildings, negative attitudes that result in prejudice and discrimination, and inadequate support – as the main factors in disabling people. Proponents of the social model argue that while physical, sensory, intellectual, or psychological variations may cause individual functional limitation or impairments, these do not have to lead to disability unless society fails to accommodate and include people regardless of their individual differences (ASI, 2010).

The term neurodiversity, stemming from the social model of disability, was coined by autism activist Judy Singer and refers to a number of conditions resulting from neurological differences such as attention deficit hyperactivity disorder, dyslexia, intellectual impairments, autism, schizophrenia and mood disorders (Armstrong, 2010). The emphasis in neurodiversity is placed on accommodating and accepting differences, and people are encouraged to focus on strengths associated with these conditions rather than focusing solely on “deficits” (Armstrong, 2010).

The role of trauma in disabilities

People with disabilities are at an extremely high risk for emotional, sexual and physical violence or abuse (Wayne State University, 2002).

• A person with a disability – regardless of age, socioeconomic status, race, ethnicity or sexual orientation – is twice as likely to be a victim of abuse than a person without a disability (Wayne State University, 2002).

• In addition to abuse by family members or intimate partners, people with disabilities are at risk for abuse by attendants or care providers. They are also more likely to experience a longer duration of abuse than people without disabilities (Young et. al, 1997).
• Street crime is a more serious problem as well. Studies have shown that people with disabilities have a four to ten times higher risk of becoming crime victims than persons without disabilities (Wayne State University, 2002).

• Emotional, physical, and sexual abuse of people with disabilities is a problem largely unrecognized by rehabilitation service providers (Young et. al, 1997).

Karen Foley, a behavioral health specialist and founder of Triple Play Connections in Seattle, says:

“I have someone right now who has a developmental disability, and her partner takes her Social Security money. That keeps her financially bound, unable to move, unable to get safe” (Foley, 2010).

**Barriers to service**

For people in abusive situations, crisis intervention may include escaping temporarily to a shelter, escaping permanently from the abuser, and having an escape plan ready in the event of imminent violence if the person must remain with the perpetrator. However, these options that many people take for granted may be problematic for people with disabilities. Here are some common barriers to accessing services:

• **Lack of accessibility.** According to the National Coalition Against Domestic Violence and the National Coalition Against Sexual Assault, inaccessibility in shelters and other advocacy services is a serious problem. These programs generally operate on very thin budgets and covering the cost of accessibility modifications and services is a substantial challenge. One study found that only about a third of providers offered safety plan information modified for use by people with disabilities, or disability awareness training for program staff, and personal care attendant services were available in only six percent of programs (Nosek et. al, 1997).

• **Lack of supportive services.** Even if the shelter itself is physically accessible, there may still be accessibility issues if the shelter is unable to meet an individual’s needs for personal assistance with activities of daily living, if there is no accessible transportation to the facility, or if the shelter staff are unable to communicate with a person who has a hearing or speech impairment (Nosek et. al, 1997).

• **Trust issues.** People with disabilities may be reluctant to disclose abuse because of worry that their disability will be used to discount their perceptions or take away their autonomous decision-making power. They may fear being judged incompetent to care for themselves or live independently. Parents may fear that they will be judged too incompetent to provide adequate parenting because of disability issues. They may have been accused of malingering in order to get benefits, or told they could do certain things if they really wanted to.
Too much focus on deficits rather than strengths. A focus on deficits and the assumed inadequacies of people with disabilities, rather than on their strengths, may contribute to a cycle of hopelessness and a view of the “helping” relationship as adversarial (Leal-Covey, 2011).

Lack of affordable services. People with disabilities may be unable to afford services if they do not have insurance or have an insurance policy that doesn’t adequately cover...
services or equipment (Leal-Covey, 2011). This can be a problem for people with middle-class incomes as well as for people who live in poverty. Managed care policies may try to limit the type or amount of services that are covered by insurance.

• *Difficulty following procedures.* A person with disabilities may have trouble completing tasks or following certain rules. Karen Foley, a behavioral health specialist and founder of Triple Play Connections in Seattle, says:

“One person I’m working with was in a homeless shelter, and her developmental disabilities were interfering with her ability to follow through with her service plan. And if she doesn’t follow through with her service plan, it affects everything. So she has been kicked out of the homeless shelter because she can’t follow her service plan. Her money from DSHS (Department of Social and Human Services) – that money has been sanctioned because she has been unable to follow through on her service plan” (Foley, 2010).

### Empowering People with Disabilities

Following are some ways for advocates and counselors to empower people with disabilities:

• Work to improve accessibility. Ensure that all services are accessible and integrated for people with disabilities, including hot lines, individual counseling and support groups. Modify shelters so they are fully accessible, including barrier-free access to sleeping rooms and common areas, architectural features that comply with the Americans with Disabilities Act, visual and auditory alarm systems and available interpreters (Nosek et. al, 1997).

• Avoid making assumptions about the needs of people with disability issues. Cecilia Leal-Covey, an advocate and consultant in Reno, NV, says:

“In Nevada, a shelter told a victim in a wheelchair to find other services because the shelter was not accessible for her. The ‘advocate’ saw the wheelchair, thought the woman needed caregiving, and denied services. The shelter was accessible for the victim and the victim did not need caregiving. The advocate made an assumption, and the victim was left on the street without options” (Leal-Covey, 2011).

• Modify safety plans as needed. Examples of modifications may include a medical alert device which can be worn at all times without suspicion and used to call for help; keeping an extra set of medical supplies or adaptive equipment at a friend’s or relative’s place; or setting up an alternative caregiver or personal assistance if needed (Hanson, 2000).

• Help individuals understand their legal rights. People with disabilities who depend on caregivers, either at home or in institutions, may need special legal protection against abuse (Nosek et. al, 1997).
• Ask about needs. While asking a question such as “Do you have special needs we should be aware of?” may feel disempowering, a general question would be appropriate to ask anyone seeking services, whether they have a disability or not. Examples of general questions would include: “Would you let me know if you need anything?” Or, “Please feel comfortable asking if you need anything.”

• Provide extra advocacy, if needed and requested. A survivor shares:

  “I was lucky I had some people that helped advocate for me and helped me advocate for myself. There were some things I needed to challenge, and I ended up having to go up the ladder two layers of management to deal with one particular situation, which was keeping my animal as a service animal. I would not have had the emotional strength for the fight, because one of my responses with PTSD was to pull back and shut down, had I not had someone helping me advocate for myself and supporting me through that process.”

• Recognize that some disabilities are invisible, but pose legitimate challenges nonetheless. A survivor shares:

  “I was poor, because I was jobless. I was homeless, and I had a mental health diagnosis. So how I was treated, in retrospect, by housing authority people, some mental health folks, the metro transit people, because I had a bus pass for people with disabilities – I was not treated very well by many different groups in society. I look back on that and I remember I would feel so ashamed because I had to use the bus pass. And sometimes the way people would look at me – because on the outside, I was physically able to move around, nobody knew what was going on behind the scenes, what was going on with me.”

Working with other providers

When collaborating with agencies or programs that serve people with disabilities:

• Advocates should collaborate with personal care attendant agencies and independent living centers to enable the provision of personal assistance services for people with severe disabilities at emergency shelters. Have on hand an extensive network of community referrals and contact numbers, including volunteers or other community resources for obtaining personal assistance (Nosek et. al, 1997).

• Don’t be afraid to ask for help. Disability-related service providers are usually eager to offer their assistance to other community providers with questions about how to make their services more accessible. Accessibility is not necessarily an expensive proposition. Sometimes improving accessibility may be as simple as relaxing a policy or rule, or giving someone more time to complete a task or goal (King, 2009).

• Provide cross-training. Train advocates on how to communicate with persons who have
hearing, cognitive, speech, or psychiatric disabilities. Staff should understand environmental barriers faced by people with physical and sensory disabilities when offering advice or referrals for obtaining shelter. Also offer training to disability-related service providers, including independent living centers and personal care attendant agencies, on recognizing the symptoms of abuse and the characteristics of potential perpetrators. These service providers should be familiar with and able to refer to resources for victims of violence or abuse in their community (Nosek et. al, 1997).

- Train law enforcement officers about the special needs of victims with disabilities. The sensitive handling of domestic violence and sexual assault against people with disabilities should be a mandatory part of the training of law enforcement personnel in every city. They need to be aware of the additional measures that may be needed to keep a victim with a disability safe from the perpetrator (Nosek, et. al, 1997).

- When making referrals, be aware of which providers and community support groups provide the best accessibility for people with disabilities (Leal-Covey, 2011).

References


Foley, K., Triple Play Connections, Seattle, WA. Personal interview with Debi Edmund, July 2010.


King, C., University of Alaska Center for Human Development. Personal interview with Debi Edmund, November 2009.


