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Interpersonal Violence and Disability: General Guidance and Specific Considerations in the Wake of COVID-19

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People with disabilities experience increased rates of interpersonal violence (IPV) across the lifespan. They also experience unique forms of, risk factors for, and barriers to reporting and addressing IPV. The COVID-19 pandemic worsened many of these risk factors and barriers, leading to new considerations for service providers. This article addresses some of those unique challenges and on ways in which the pandemic has impacted them. Additionally, suggestions are provided for how to identify and address violence against clients with disabilities and make a broader call to address the systemic and structural issues that underlie the epidemic of violence against people with disabilities.

People with disabilities experience increased and elevated rates of interpersonal violence (IPV) across the lifespan (R. Hughes et al., 2011), including in both childhood (Jones et al., 2012) and adulthood (K. Hughes et al., 2012). In a systematic review of 21 studies, R. Hughes and colleagues (2011) found that the lifetime prevalence of IPV ranged from 26.0%-90.0% for women with disabilities and 28.7% to 86.1% for men with disabilities. Likewise, in a meta-analysis comparing adults with and without disabilities, K. Hughes and colleagues (2012) reported that adults with disabilities were 1.5 times as likely as non-disabled adults to experience abuse. This increased risk is seen across disability types (R. Hughes et al., 2011), although people with developmental and psychiatric disabilities are at particularly high risk for experiencing abuse (K. Hughes et al., 2012).

Defining Interpersonal Violence in the Context of Disability

For people with disabilities, IPV may come from a variety of perpetrators, including intimate partners, other family members, caregivers and personal care assistants, friends, medical professionals, and individuals who fill multiple roles (e.g., a family member or intimate partner who provides assistance with personal care) (Lund et al., in press; Powers et al., 2009). Similarly, IPV against people with disabilities can take many forms including physical, sexual, and psychological abuse (K. Hughes et al., 2011), financial abuse (Oschwald et al., 2015), and disability-related abuse (Lund et al., in press; McFarlane et al., 2001; Powers et al., 2008; Saxton et al., 2001, 2006). Disability-related abuse may take many forms including refusing to provide necessary and expected personal care assistance (e.g., not helping an individual with paralysis turn over in bed in order to prevent pressure ulcers) or refusing to help feed a client who cannot do so independently. Alternatively, it may come from denial or destruction of assistive technology or medical or mobility aids (e.g., denying someone access to their wheelchair to prevent them from leaving or destroying someone's communication device to prevent them from telling others about the abuse). People with disabilities who experience IPV may experience multiple types of IPV from multiple perpetrators; in many cases, the violence will be chronic, both in terms of individual violent relationships (Copel, 2006; Nosek et al., 2001) and across the individual's lifespan as a whole (Hughes et al., 2019; Platt et al., 2017) .

Physical and Psychological Sequalae of IPV in People with Disabilities

As with the general population (Nicolaidis et al., 2004), IPV has been linked to numerous physical and psychological sequalae in people with disabilities (Barrett et al., 2009; Coston, 2019; Hughes et al., 2019), including depressive and post-traumatic symptoms, gastrointestinal symptoms, pain, fatigue, and cardiovascular issues (Hughes et al., 2019; Nicolaidis et al., 2004). These symptoms may manifest as new-onset conditions or injuries but may also represent exacerbations of pre-existing conditions (e.g., flares or worsening of pre-existing chronic medical or psychiatric conditions) or secondary health conditions related to a pre-existing disability (e.g., pressure ulcers in an individual with a spinal cord injury) (Hughes et al., 2019). Additionally, the health effects of IPV may be worsened if a perpetrator interferes with their victim's access to medical care (Nicolaidis, 2007). Thus, IPV represents both a threat to the safety of individuals and a broader public health issue.

Call to Action

Human services professionals and clinicians from a number of fields, including rehabilitation professionals, play important roles in identifying and responding to IPV in people with disabilities (Chowdhury, 2020; Lund & Thomas, 2017; Swedlund & Nosek, 2000). As "frontline" professionals, these individuals are critical in the identification of and response to violence and other crises in their clients and may be the first individuals to whom clients report abuse (Lund & Thomas, 2017; Swedlund & Nosek, 2000). However, many professionals lack adequate training in the intersection of violence and disability (Swedlund & Nosek, 2000), often leading to gaps in care and even harm to victims of IPV (Lund et al., 2017). Thus, this article provides an overview of key issues related to violence against people with disabilities, including ways in which the COVID-19 pandemic has impacted these issues, and provides actionable guidance for practitioners.

Working with IPV Survivors with Disabilities: General Considerations

Identification, Reporting, and Assessment

Potential signs of abuse. As mentioned above, IPV often has considerable physical and psychological effects on victims (Hughes et al., 2019; Nicolaidis et al., 2004). Some of these effects may present with physical and emotional changes or effects (Neno & Neno, 2005). For example, someone who is experiencing physical abuse may have unexplained or frequent bruises, cuts, broken bones, or other injuries, and someone who has experienced sexual abuse may have injuries to or infections of the genitals (e.g., sexually transmitted infections [STIs], urinary tract infections [UTIs]) (Neno & Neno, 2005). As mentioned above, someone who is experiencing disability-related abuse may have physical effects that result from it, such as weight loss from denial of food or assistance with feeding, pressure ulcers from not getting proper or timely assistance turning over, or urinary tract infections from lack of assistance with toileting or changing soiled clothes (Hughes et al., 2019; Lund, 2020). Psychological signs of abuse may also be present, including fear of certain caregivers or locations and seemingly unexplained changes in mood or behavior; financial abuse may present as unexplained loss of money, difficulty paying bills, or unusual, unexplained purchases (Neno & Neno, 2005).

Identifying abuse from signs and symptoms alone can be difficult, as there may be other, non-IPV-related explanations for many of these signs. For example, physical injuries could result from benign accidents or even intentional self-harm; UTIs may be related to simple chance or lack of knowledge of appropriate post-bowel movement hygiene; STIs may result from consensual sexual relationships; and behavioral and mood changes may be a sign of psychiatric illness or psychological distress unrelated to IPV. Although these types of signs should cause practitioners to consider abuse as part of a differential diagnosis and assessment, the presence of one or more potential warning signs should not be considered to be definitive "proof" of abuse.

Indeed, if there are other causes of these issues, they need to be addressed appropriately. For example, an individual who experiences STIs after starting a consensual, healthy sexual relationship needs to be counseled on safer sexual practices. Similarly, a client who is frequently experiencing physical injury due to a loss in vision may need additional orientation and mobility training to learn how to navigate their environment more safely. Likewise, changes in mood or behavior may trigger a need for psychiatric, psychological, or neurological assessment and treatment.

When assessing for potential abuse, it is important to communicate with the individual in a private location as much as possible. As discussed above, perpetrators of violence against people with disabilities often have formal or informal caregiving duties for the person being abused (Saxton et al., 2001, 2006)—having the potential perpetrator present while discussing possible abuse may create a safety issue for the client (Lund et al., 2015; Oschwald et al., 2009). Having screening measures and protocols available in multiple accessible formats (e.g., plain language, screen-reader accessible, large-text) will increase the likelihood that a caregiver will not need to be present during these conservations (Nicolaidis et al., 2020; Oschwald et al., 2014); examples of such tools are provided below. If a provider does reasonably suspect that abuse has occurred or may be occurring after a clinical assessment, they may be required by state law to engage in mandatory reporting (Lund & Thomas, 2017); this is discussed in more detail in the "Mandatory Reporting" subsection below.

Barriers to disclosure. Despite the high rates of IPV victimization seen in people with disabilities and the negative health effects that result, there are considerable barriers faced by people with disabilities that make it even more difficult to report abuse or leave a violent relationship, which is a difficult and dangerous task for anyone (Miller et al., 2012). For example, some individuals with disabilities, especially those with intellectual, psychiatric, or communication disabilities, may face difficulties in getting other individuals to believe their experiences or understand their communication thereof (Bryen et al., 2003; Petersilia, 2001). Additionally, many individuals with disabilities depend on the perpetrator or perpetrators of their abuse for assistance with daily life tasks and personal care (Lund et al., 2015; Powers et al., 2008; Saxton et al., 2001, 2006). This often puts IPV victims with disabilities in situations where they feel as though they must choose between continuing to endure abuse and risking going without vital—and often life-sustaining—personal care (Lund et al., 2015; Powers et al., 2008; Saxton et al., 2001, 2006). Furthermore, because of the high poverty and low employment of people with disabilities (Erickson et al., 2019), people with disabilities may also be particularly vulnerable to being financially dependent on the perpetrator of their abuse, especially if the perpetrator also functions in an official compacity, such as a representative payee for disability benefits, or has access to the individual's credit cards or account information (Lund et al., 2015). Perpetrators of abuse have long created and reinforced isolation and dependency as a way to trap and control victims (Miller et al., 2012), and the unique needs and situations of people with disabilities often makes them even more vulnerable to such tactics.

Mandatory reporting. In addition, reporting abuse is often complicated by the fact that, in many states, adults with disabilities fall under mandated reporting laws as "vulnerable adults," although the exact definitions thereof vary heavily by state ((National Adult Protective Services Association [NAPSA], 2013). This means that providers are often required by law to inform Adult Protective Services (APS) or a similar state agency if they know or suspect that an adult with a disability is experiencing abuse. Although these laws are well-intentioned, they often lead to a hesitance to report abuse among people with disabilities (Lund et al., 2015; Oschwald et al., 2009; Saxton et al., 2001, 2006) due to fear of potential negative consequences stemming from APS involvement, such as retaliation from the perpetrator, isolation from family, or loss of independence (Lund et al., 2015; Oschwald et al., 2009; Saxton et al., 2001, 2006).

When working with individuals with disabilities, it is critical that service providers know their state mandatory reporting laws well and that they inform all clients about their mandatory reporting duties at the beginning of the professional relationship (Lund & Thomas, 2017). This will allow individuals with disabilities to make truly informed choices about whether or not to disclose abuse, allowing them to weigh the specific costs and benefits of their own situation (Lund, 2020). If a mandated report has to be made, providers may want to ask clients if they would like to be involved in the reporting

process as a way to potential increase their autonomy and ownership of the process (Lund et al., 2015).

Accessible screening tools. Because of the unique barriers to reporting and leaving violent relationships experienced by people with disabilities, specific interventions and reporting tools have been developed to help providers address these issues. One tool that has been used successfully in multiple populations of individuals with disabilities is the audio computer-assisted self-interview (A-CASI) technology (e.g., Lund et al., 2015; Oschwald et al., 2009, 2014, 2015). This technology has been used in both strictly assessment (Oschwald et al., 2014) and combined client education-assessment contexts (Lund et al., 2015; Oschwald et al., 2009, 2015) and offers maximum accessibility via features like enlargeable text, speech-to-text features, sign language captioning, video captioning, hotlinks to explain potentially confusing or new terms, and screen-reader accessibility. Importantly, these accessibility features allow many people with disabilities to engage with the tool without assistance from another person (Lund et al., 2015; Oschwald et al., 2009, 2014, 2015), allowing them to learn about and even report abuse without triggering a mandatory report. This allows for true privacy for the person with a disability and allows them more control over if, when, and how they report violence, facilitating maximum autonomy and safety. Additionally, these A-CASI programs, as well as some independent assessment tools (e.g., the Abuse Assessment Screen-Disability [AAS-D]; McFarlane et al., 2001) include questions about disability-related abuse, which is generally not assessed by abuse screening measures developed for the general population (Lund et al., in press).

Safety Planning and Intervention

Safety planning is a strategy in which individuals develop comprehensive plans and supports that can increase their chances of surviving and eventually leaving a violent situation as safely as possible (Hughes et al., 2010). Because not all individuals with disabilities who are experiencing abuse may choose to disclose it, providers may find it beneficial to discuss safety planning with all clients (Lund, 2020), especially for clients who require personal care assistance for critical life activities. Clients would benefit from a back-up caregiving plan regardless of whether or not they are experiencing abuse. By not tying safety planning to abuse specifically (unless requested by the client), providers can equip clients with potentially life-saving knowledge without requiring them to disclose abuse (Lund, 2020). If a client does disclose abuse, a safety plan can be developed that addresses their specific needs and concerns, such as arranging back-up care if they leave the perpetrator and ways that they can more safely plan to leave if desired (e.g., identifying friends who can assist with emergency care, identifying places and ways to store extra medical equipment or supplies).

It is paramount that providers remember that leaving a violent relationship can be extremely dangerous, and that not all clients will be ready to leave violent relationships even if they do disclose abuse (Hughes et al., 2010; Miller et al., 2012; Nicolaidis et al., 2005). Thus, providers should counsel individuals who have disclosed or may be experiencing IPV in ways that respect their autonomy and maximize their safety, as opposed to simply expecting all clients who are experiencing violence to immediately leave those relationships (Hughes et al., 2010; Lund et al., 2015; Nicolaidis et al., 2005). It is critical that these conversations are approached with empathy and respect for the individual. Providers must also avoid victim-blaming statements, such as faulting them for requiring personal care assistance or for not leaving the violent relationship sooner (Oschwald et al., 2009; Lund et al., 2015; Nicolaidis et al., 2005). Likewise, providers should be careful to avoid language that suggests the individual is to blame for their abuse due to their disability or associated symptoms or needs (e.g., "If you didn't need so much care, maybe he wouldn't have left you on the toilet for three hours"; "It's hard living with an autistic person—of course, she reached her limit and hit you"), especially given the tendency of many healthcare professionals to have ableist biases (VanPuymbrouck et al,. 2020). In fact, providers should actively work to counter ableist and other victim-blaming messaging and statements, clearly conveying that the abuse is in no way the person's fault and that everyone deserves a life from abuse (Hughes et al., 2010).

It may also be helpful to have trustworthy, safe resources to give to clients, especially those who are or may be experiencing abuse. One such example is VAWNet (https://vawnet.org/), which contains evidence-based information about abuse, including targeted at individuals currently experiencing IPV. These resources include information on domestic violence and other forms of violence and trauma in general, with a focus on interpersonal violence. Articles on VAWNet also address the needs of specific communities. For example, the site hosts specific collections of articles written on teenage dating violence, domestic violence in gender and sexual minority (i.e., LGBTQ+) relationships, and violence against people with disabilities, among others. Information is targeted to both professionals and laypeople and includes statistics, resources, and discussions of barriers, considerations, and specific topics of concern. The site also includes links to other resources and organizations that address violence, trauma, and marginalized communities. Of note, VAWNet has a "emergency exit" button, which immediately wipes the site from the visitor's web history and redirects them to neutral Google search page, thereby decreasing the likelihood that the perpetrator would become aware that anyone in the household was looking up information on IPV. This feature is commonly used for domestic and interpersonal violence-related websites to help promote safety and privacy (Lund et al., 2015).

Intersectionality. When working with individuals with disabilities who have or may be experiencing IPV, it is also important that providers consider other aspects of client's identities, such as race/ethnicity, language, sexual orientation, and gender and how those interact with the experiences of both violence and disability (Brown, 2017; Lightfoot & Williams. 2009; Lund, et al.,2017). For example, people with disabilities from marginalized racial and ethnic or language backgrounds may struggle to find services that are culturally competent in both race and disability. For example, individuals who are both Black and Deaf often struggle to find sign language interpreters who are fluent in Black American Sign Language dialects, leading to gaps in communication and poorer quality of care (Lightfoot & Williams, 2009). Men with disabilities who have experienced abuse may have difficulties finding victim services organizations that serve male victims due to the erroneous assumption that men cannot experience abuse (Lund et al., 2015). Similarly, individuals with disabilities who are sexual and/or gender minorities (i.e., members of LGBTQ+ community) may also struggle to find providers that are both LGBTQ+- and disability- culturally competent (Lund, 2021). It is important that providers offer the most culturally competent care possible by being willing and able to consult with colleagues and organizations to address any questions or gaps in knowledge, training, or comfort as needed (Lund, et al., 2017).

Working with IPV Survivors with Disabilities During and After the COVID-19 Pandemic

The ongoing novel coronavirus (e.g., COVID-19) pandemic created drastic social changes, many of which had particularly strong effects on people with disabilities (Lund et al., 2020). For example, many people with disabilities faced the difficult decision of whether to seek routine—or even emergent—medical care (i.e., increasing their risk of exposure to COVID-19) or to delay care and potentially experience worsening of new or pre-existing conditions as a consequence of delayed care (Lund et al., 2020). These decisions were further complicated by the fact that people with disabilities are more likely to have secondary conditions, such as obesity or cardiovascular conditions (Hughes et al., 2019; Nosek et al., 2006, 2008), that put them at increased risk for serious complications or death if they were to contract COVID-19 (Onder et al., 2020). People with disabilities who rely on assistance with personal care faced a similar difficult choice regarding using caregivers who lived outside the home (Lund, 2020). On one hand, such individuals provide very important care and often have experience in attending to that person's specific needs. On the other hand, having an outside person enter the home and provide care involving extended close contact also increases the risk of exposure to COVID-19, especially given the potential for infection from pre-symptomatic or asymptomatic individuals (Bai et al., 2020). As a result, many people with disabilities, who were already at increased risk of social isolation before the pandemic, were even more isolated as a result of necessary health and safety precautions (Lund et al., 2020).

The social isolation created by the COVID-19 pandemic and associated stay-at-home orders also created and strengthened conditions that facilitated the perpetration of IPV (Moreira & da Costa, 2020). Stay-at-home orders had the dangerous effect of creating situations where victims of IPV were constantly in private quarters with the perpetrators of their abuse (Froimson et al., 2020; Gabrielli & Lund, 2020), creating increased opportunities for the perpetrators to engage in violent behavior and sharply decreased opportunities for victims to escape the abuse or seek support elsewhere. Data from early in the pandemic indicate an increase in calls to law enforcement regarding domestic violence (Boserup et al., 2020), as well as an increase in serious physical injuries resulting from intimate partner violence (Gosangi et al., 2021) during the initial COVID-19 lockdowns.

Given that the pandemic and associated public health measures had a disproportionate effect on people with disabilities, it is plausible that they may have experienced even more enhanced vulnerability to IPV during this time, especially as the pandemic greatly limited access to truly private medical care, outside social support, and back-up caregivers, all of which have been highlighted as critical in addressing IPV against people with disabilities (Hughes et al., 2009; Lund, 2020; Lund et al., 2015; Oschwald et al., 2009). As providers work with individuals with disabilities during and after the COVID-19 pandemic, they must be aware of the increased vulnerabilities that this population has faced, including the possibility for new or worsening IPV or physical or psychologic sequalae thereof. Previously developed safety plans and caregiving plans may need to be reviewed and updated, and providers should consider accessible online websites for patient education (Lund, 2020).

Advocacy and Addressing Systemic Violence and Trauma

In addition to addressing IPV specifically, providers should consider the cumulative impact of other recent trauma, such as community grief and loss due to COVID, healthcare discrimination against individuals with disabilities, and violence against Black and Black disabled individuals (Andrews et al., 2020; Lund & Ayers, 2020; Lund et al., 2020), on their clients with disabilities and provide general disability- and intersectional-competent care that takes into account the effects of cumulative and multimodal trauma on health and well-being (Lund et al., 2020). Similarly, providers may wish to advocate against the systemic forces that contribute to violence against people with disabilities, such as ableism in both healthcare and general society, devaluation of disabled lives, and inaccessibility and lack of disability cultural competence among violence and healthcare service providers (Lund, 2020, 2011).

Conclusion

Interpersonal violence is a chronic and pressing issue for people with disabilities, and their needs often go unaddressed in broader conversations around violence. As professionals working with individuals, we must be aware of the unique factors that influence the experience of IPV and help-seeking among people with disabilities and continue to conduct research and improve practices in a post-COVID world.

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