

# Invisible intersections: Understanding the complex stigmatisation of women with intellectual disabilities in their vulnerability to gender-based violence

Talia Meer and Helene Combrinck

## abstract

Of the range of disabilities, intellectual disabilities are often the most complex and least understood. The effects of the disability and related negative social attitudes and perceptions combine with the pernicious effects of sexism and misogyny, so that women with these kinds of disabilities are frequently and disproportionately subject to gender-based violence (GBV). This article explores the stigmatisation that renders women with intellectual disabilities more vulnerable to victimisation from the perspective of service providers in the disability and GBV sectors. The data are taken from a larger study on GBV and access to justice for women with intellectual and psychosocial disabilities undertaken in the Western Cape, Gauteng, and KwaZulu-Natal, wherein we interviewed 58 service providers at disability and GBV organisations. In the process, service provider narratives indicated that the experiences of women with intellectual disabilities, including their vulnerability to and experiences of violence, are mediated by multiple complex social perceptions and myths. According to our findings these include the general view that people with disabilities are less valuable, cultural myths and superstitions about disability, fear and shame associated with 'disabled' sexuality, beliefs about the lack of credibility of persons with intellectual disabilities, and the tendency of persons with disabilities to internalise negative views about themselves. These myths and perceptions are not mutually exclusive, but combine and interact in complex and compound ways, often rendering the victimisation of women with intellectual disabilities invisible, or intractable. This article aims to highlight the relationship between intellectual disabilities and prevailing social attitudes as a central concern in the prevention of and responses to violence against women with intellectual disabilities.

## keywords

intellectual disability, gender-based violence, stigma, South Africa

## Introduction

The problem of gender-based violence (GBV) has in recent years received much attention in South Africa. However, violence committed against women with disabilities is one aspect of GBV that has been neglected almost entirely. Popular discourses tend to gloss over

the intersection of disability and GBV, assuming that people with disabilities are either protected from or not targeted for violence, even though disability is not a protective factor against violence (Nosek *et al.*, 2001).

As a result, there is little information available on the nature and extent of violence

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against women with disabilities in this country, or on what factors make them vulnerable to such violence. This article goes some way toward addressing that gap.

Rooted in the social model of disability that asserts that “impairment is socially created and meaning is given to it through a variety of social practices [and sees] disability [as] a construct of the social and economic structures of a society at a particular historical point”, this article highlights prevalent social constructions of women with intellectual disabilities (Chappellet *et al*, 2001:46). Our findings suggest that women with intellectual disabilities in South Africa are subject to multiple myths, stereotypes and negative attitudes. Each of these has a powerful stigmatising effect, but combined they render women with intellectual disabilities especially vulnerable to violence, yet invisible and silent.

### Literature review

Whilst evidence on violence against women with disabilities is limited and scattered, two aspects are widely accepted, and supported in the literature: (1) people with disabilities, particularly women with intellectual disabilities, are more vulnerable to violence (Barger *et al*, 2009), especially sexual violence; and (2) accurate, comprehensive data collection on the nature and extent of the problem is nearly impossible owing to systemic barriers to collection (Rosen, 2006; Hanass-Hancock, 2009).

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Ironically, in developing contexts where the problem is probably more severe due to limited access to health care and higher levels of interpersonal violence, the barriers to data collection are also more profound. For this reason most existing research emanates from developed contexts. In the United Kingdom incidence studies have produced estimates of rates of GBV against people with intellectual disabilities ranging from 0.5 per 1000 of the population of people with learning disabilities (Brown and Turk, 1992) to 2.88 per 1000 (Dunne and Power, 1990). Prevalence ranges from 8% (Buchanan and Wilkins, 1991) to 58% (Hard and Plumb (1987) cited in McCarthy and Thompson, 1996:205). A study by McCarthy and Thompson (1997) found a

prevalence rate of 25% for men and 61% for women.

Little information is available on the nature and extent of violence against women with disabilities in South Africa,<sup>1</sup> apart from the results of one small-scale exploratory study by Naidu and colleagues in 2005. However, this study focused on women with physical and sensory disabilities and expressly excluded women with intellectual disabilities.

Further, due to barriers to reporting, victims with disabilities generally are likely to suffer multiple episodes or prolonged violence. The National Center for Injury Prevention in the United States of America indicates that only 19–23% of all sexual violence cases perpetrated against people with disabilities were limited to one episode (Rosen, 2006). In addition, evidence suggests that people with intellectual disabilities are more at risk than those with, for example, physical disabilities (Sobsey, 1994). Intellectually or developmentally impaired adults are unlikely to disclose violence, since communication may be difficult and they are more reliant on caregivers and are more likely to be institutionalised.

As data of this kind are not available for South Africa, one can only speculate that the situation is similar, if not worse. Given the international literature, media reports, anecdotal evidence, practitioner experience and the few scarce studies on the topic from South Africa, we can safely assume that women with intellectual disabilities in South Africa are especially threatened by GBV.

Given this assumption, understanding the complex vulnerability of women with specific disabilities within the South African context is an essential step toward addressing the phenomenon, and creating a more robust evidence base on the subject.

There has been some analysis of why women with intellectual disabilities might experience a greater vulnerability to abuse. These include both social perceptions that inform the experiences of disability, and the physical realities of living with disability (such as dependence, and physical limitations to escaping). It is the former, those aspects that are related to social perceptions and stigmatisation, that are of particular relevance to this article. These might include the combined cultural devaluation of women and persons with disabilities, overprotection in

relation to both internalised social stereotypes and reduced societal expectations, the denial of sexuality in women with disabilities, the perception that women with disabilities are sexually deviant, a lack of sexuality education, perceived lack of credibility of some survivors, social isolation, and perpetrators' perception that there is a lower risk of discovery (Rohleder and Swartz, 2009; Smith, 2007; Rosen, 2006; Milligan and Neufeldt, 2001; Tepper, 2000; Andrews and Veronen, 1993). Waxman (1991) has a much simpler but chilling explanation for why violence, including sexual violence, is disproportionately directed at people with disabilities: hatred. Waxman uses a disability rights perspective and assesses the socio-political context in which these crimes occur to argue that hatred of persons with disabilities is a core driving force.

## Methodology

The findings elucidated in this article are drawn from the data of a larger study on GBV and access to justice for women with intellectual and psychosocial disabilities. This study used a qualitative research design, with semi-structured interviews. The authors conducted a total of 58 interviews in 2012 across the three sites (n=58): 15 in the Western Cape, 19 in KwaZulu-Natal and 24 in Gauteng. The focus of the interviews was to gather information about the barriers encountered by women with disabilities who have experienced GBV when they approach the criminal justice system, to discover how service providers and other stakeholders have responded to these barriers, and to compile their recommendations for addressing these obstacles in future. All participants were given information about the study beforehand, and gave their informed consent at the beginning of each interview.

Interviews were conducted with two categories of participants: Direct service providers to women with disabilities, and indirect service providers. The direct service providers to women with disabilities were recruited from disability rights organisations. The majority of these organisations focused on mental health and disability specifically, although some were broad disability organisations (e.g. those including physical disability). Organisations offered counselling and support services, school and residential facility placement where possible,

skills programming and protective workshops, and income-generation opportunities. Participants worked largely with individuals with mild or moderate intellectual disability. The persons that were interviewed included operational representatives (e.g. counsellors and psychologists), and managers as well as support and care workers. In the case of indirect service providers, these participants were recruited from organisations dealing with violence against women more generally, which provided counselling, court preparation and legal advice services, and were largely social workers and counsellors.

Interviews were transcribed verbatim and themes were identified based on a close reading of all manuscripts. These themes were used to focus and code information, which was analysed for core issues, ideas and patterns.

The question whether we should interview women with disabilities who have experienced GBV and have approached the criminal justice system is one that received considerable attention in our design considerations. On the one hand, we were conscious of the maxim 'nothing about us without us', which has now been given formal recognition in the Convention on the Rights of Persons with Disabilities, beyond its initial utility in advocacy. On the other hand, we were also mindful of the fundamental principle of 'no harm' underlying ethical research. Due to the real possibility of secondary victimisation, the complex nature of informed consent when interviewing persons with intellectual disabilities, as well as difficulty accessing participants with intellectual disabilities given the protective attitudes of parents and caregivers, we decided not to include the direct 'voices' of women with intellectual disabilities but to focus on the perspectives of those service providers that work most proximally with them. This is not without its limitations.

## Findings

Data analysis of service provider narratives revealed that the experiences of women with intellectual disabilities are mediated by multiple complex social perceptions and myths, specifically stigma, that renders women with intellectual disability especially vulnerable to GBV. Whilst stigma and myths are grouped thematically, it is important to bear in mind that they do not occur in isolation but

intersect, combine and multiply to powerful and detrimental effect.

### ***Stigma: Society, sexuality and the self***

#### *Generalised disability-related stigma*

To have any kind of disability is not only a physical or mental condition, but also a social and stigmatised one, where the type of disability, its visibility, its severity, and whether it is physical or mental, mediate the degree to which a person with a disability is socially compromised (Gershick, 2000). Almost universally, people with 'mental' disabilities, including intellectual disabilities, are the least understood and the most stigmatised. Fortified by the medical model of disability, which emphasised disability as a defect of the individual as opposed to a product of a hostile social and physical environment (Chappell *et al*, 2001), generalised disability-related stigma tends to orbit around ideas about inferiority and incapability.

Hence for many, stigmatisation often begins at the identification of the disability or diagnosis. Many families react negatively, setting a precedent for social reactions, ideas and attitudes about disability that informs individuals' experience of their disability throughout their lives (Heiman, 2002). For example, participants in KwaZulu-Natal and the Western Cape noted that they frequently saw cases of domestic violence triggered by the birth or diagnosis of a child with an intellectual disability. In such cases patriarchal attitudes and existing risk factors for domestic violence intersect with negative attitudes about disabilities – that these children are 'abnormal, incapable and burdensome' – so that the violence is not usually directed at the child, but at the mother who is held responsible for producing such an 'undesirable' child.

patriarchal attitudes and existing risk factors for domestic violence intersect with the negative attitudes about disabilities

Such stigmatisation is replicated and amplified in wider society and persons with disabilities are often devalued, isolated, and subject to violence and verbal abuse. They are widely referred to by derogatory names, and humiliated. Pervasive social stigma often means that employers are hesitant to employ even high-functioning persons with intellectual disabilities. A Gauteng participant explained that

in instances where preference is given to persons with disabilities due to affirmative action policies, employers favour persons with physical disability, because they 'know how to handle it'. Although many organisations try to facilitate relationships between potential employers and their clients, for many employers the view that persons with disability are innately incapable, unproductive or an added liability are unchangeable. Such stigmatisation contributes to the pervasive view that people with disabilities are not worthy, especially in a society where human worth is strongly associated with economic worth, and also exacerbates financial dependency of women with disabilities, who may not leave abusive circumstances out of necessity.

These prejudices tend to make people with disabilities less visible to society and more isolated. On the one hand, because they are neither seen nor seen as desirable (Chenoweth, 1997), sexual abuse is deemed unlikely for people with disabilities, making the problem invisible. At the same time isolation means they may not have the social and personal networks to buffer them from abuse.

Disability-related stigmatisation is especially pernicious in a context of commonplace misogyny. A social worker in the Western Cape explains:

"Even if you [women] do not have a disability you are seen as the lesser, especially in our communities, and, people can take advantage of you. So, when you have a disability it is more [risky] because they think that they can do something to that person and the person cannot defend themselves and cannot be able to say that this is the person that did this to me." (Participant 51)

The second part of this quote captures another aspect of disability-related stigma: often because women with intellectual disabilities are seen as incapable, perpetrators perceive them as 'perfect victims' – compliant, silent and invisible. This may be related to infantilisation of the person with the disability, and their stigmatisation as unwitting or gormless. Andrews and Veronen (1993) attribute this to the fact that through the denial of their human rights, including appropriate accommodation, adaptive methods and equipment, society perceives people with disabilities as powerless.

### *Cultural myths and superstitions*

According to participants, in some South African contexts intellectual disability is associated with the supernatural – the product of witchcraft, being cursed, ancestral or demon possession. Whereas stigma based on perceived inferiority is linked to the idea of people with disabilities being less than (perfectly) human, this kind of extreme othering moves disability to a realm that is not even human. In Gauteng a social worker explained that among several of her clients, intellectual disabilities are still widely associated with demon possession, while in KwaZulu-Natal a disability outreach worker explained that in Zulu mythology intellectual disabilities are seen as the result of not having followed customs and being cursed by ancestors, and as portending bad luck. As a result it is not uncommon for people to seek the help of traditional healers in order to ‘treat’ intellectual disabilities.

Such ideas are not new, nor confined to these contexts: in a review of the social representations of people with disabilities, Marks (1999) includes the historical representation of disability as the result of divine punishment for a sin.

Pervasive misogyny means that mothers of persons with intellectual disabilities in particular are often scapegoated for the perceived misfortune:

“You know the mum is always carrying the burden for the whole family; it’s always the mum ... They always said it’s because of you, because you don’t belong to this family, you came out from the other family, and then you join us, so all this thing comes with you. So all, especially the female parent, they are always having a heavy story.” (Participant 10.1)

As a result the person with the intellectual disability and their families (or mothers specifically) may be ostracised by the extended family or community. As this kind of stigma predominates in poorer, rural communities, it is largely poor black women and people with disabilities who are affected by it. Whilst other findings resonate with the contemporary international literature, this form of stigma is unique to the South African context and bears further investigation, especially because of its impact on the most marginalised.

### *Stigma and sexuality*

In a seminal work on the subject, Craft (1987) describes two prevalent constructions of sexuality in persons with intellectual disabilities: being regarded as ‘forever children’ and thus asexual, or contradictorily, as having strong sexual inclinations and limited control. The prevalence of these constructions has been borne out by subsequent studies (Hanass-Hancock, 2009; Nosek *et al.*, 2001; Rohleder and Swartz, 2009). The result then is that women with disabilities are not seen as having sexual agency; instead there are two stigmatised statuses (women and disabled) that intersect, such that they experience “sexism without the pedestal” (Gerschick, 2000:1265).

On the one hand the myth that women with intellectual disabilities are ‘hypersexed’ may be linked to the fact that they may not be aware of gendered social norms, so may behave in ways that are perceived as sexualised, even if that is not their intention. A participant who works in the GBV sector explains that people may get the wrong impression because often persons with intellectual disability are very friendly and want to “chat to everybody and hug everybody” (Participant 54). Participant 14, employed at a disability-rights organisation, confirms this saying that this may be a “potential danger for them, because sometimes you don’t know what the other person is perceiving that hug or that smile to mean”. Similarly, Participant 35, a disability-rights advocate, provides an example:

“Because they have, part of the [disability] is that you don’t, you’re socially quite inept. And so you can do really inappropriate things, like for instance not wearing your underwear properly. Especially for those who have not had any access to the right education, intervention and support and therapies. And so they can be really really open to all kinds of abuse.”

On the other hand, women with intellectual disabilities also may not know how to express their sexuality, and may not have the inhibitions that govern ‘conventional’ behaviour, which contributes to damaging myths about their sexuality. One service provider, a parent of a young woman with intellectual disability herself, explains:

"You get this absolutely ridiculous thing where everybody thinks they are just so over-sexed. Therefore it's fine. And they are not. The fact that they don't have inhibitions is something else. But I mean it is the same as a normal person, you know, [but] they know to take it to the bedroom or take it privately. Our guys will learn that, but after a time. It just doesn't come naturally. So therefore they've got this reputation and therefore they are easy targets." (Participant 34.2)

This quote raises another important aspect of stigmatisation of the sexuality of women with intellectual disabilities specifically. Whilst service providers in the disability sector seemed to agree that women with intellectual disabilities should develop and express romantic and sexual desires as anyone else does, very few organisations provided routine sexual education for their clients. The participant quoted above epitomises the conflicting feelings of caregivers and parents of women with intellectual disabilities. She recognises that women with intellectual disabilities may "have genuine relationships with genuine feelings" and that these relationships can and do "go further", but as the manager of a disability organisation she admits that her organisation does not provide any form of sexual education (Participant 34.2). Further, in her capacity as a mother she does not feel comfortable discussing sexuality with her daughter, who has an intellectual disability, even though she has had such a discussion with her other (non-disabled) child.

The experiences of caregivers and parents in this study are strikingly similar to those described by McKenzie (2013), who found in her study in the Eastern Cape that people with disabilities (although not intellectual disability) were much less prepared and engaged with their developing sexuality than their siblings, and where families actively and tacitly discouraged the sexuality of people with disabilities, in part out of a desire to protect them.

although stigma around the sexuality of women with disabilities may help to explain sexual violations, it does not excuse them

Another participant explains that the anxiety around persons with intellectual disability engaging in sex comes from the infantilisation

of the disability but also from "fear of reproduction, and fear of disease", tied to myths that persons with disabilities will automatically have children with disabilities (Participant 18). This is supported by numerous authors on disability and sexuality (for example Craft, 1987; Tepper, 2000; Milligan and Neufeldt, 2001; Rohleder and Swartz, 2009).

Whilst some women do get access to appropriate sex education, many do not due to the tendency to see persons with disabilities as "forever children", and thus without sexual agency (Craft, 1987). Our findings show that due to pervasive infantilisation, many caregivers, wanting to protect women with intellectual disabilities, intentionally withhold or block sexual education in an attempt to discourage romantic and sexual relationships, even resorting to punitive legal measures. As a result women with disabilities find it difficult to form long, stable partnerships in which they can practice safer sex, experience sexual pleasure and be protected from violence (Hanass-Hancock, 2009). In addition, they are often not equipped to deal with sexual advances, coercion and violence, nor to report it when it occurs (Hanass-Hancock, 2009; Bryen, 2014). Specifically, not having the necessary vocabulary or the confidence to talk about their own bodies and sexual behaviours is a serious barrier to disclosure of violence. Participant 45 notes that when she is trying to solicit accounts of abuse she often encounters unfamiliar or made-up words for genitals, as women do not know how to refer to their own bodies, and that when she tries to clarify what they mean "they just clam up".

It is vital, however, that although stigma around the sexuality of women with disabilities may help to explain sexual violations, it does not excuse them. In fact, perpetrators often capitalise on myths to legitimise and excuse their behaviour, and to further blur the lines in a context where consent is often not foregrounded in sexual interactions. Most perpetrators know their victims, and are therefore aware of their intellectual disability, and so can account for 'inappropriate' or unusual behaviour and should also be aware of related limitations for informed uncoerced consent.

As Jill Hanass-Hancock (2009) also found, in South Africa, where GBV is very prevalent and women are already vulnerable, such misconceptions about the sexual

availability and intentions of women with intellectual disability render them extremely vulnerable to sexual coercion and violence.

*Stigma that women with intellectual disabilities should not be believed*

The misperception of women with intellectual disabilities as unreliable and untrustworthy is deeply harmful, contributing to their vulnerability to victimisation, as the perpetrator may think that should she try to report, she would not be believed anyway. According to some service providers who were interviewed, some individuals with intellectual disabilities may have active imaginations, mimic behaviours that they see on television or elsewhere, confuse reality or tell white lies. However, as with the general population, false disclosures among women with intellectual disabilities are negligible, and a report is most likely based on a real experience of violation:

“That they are there, telling you something that happened to them – it might not have happened on that day, it might not have been that perpetrator, but something happened to them. Something deeply violent and personal.” (Participant 45)

People with intellectual disabilities may not always perceive time or space in conventional and accepted ways, leading to confusion or misunderstandings around when something took place, or where, contributing to the view that women with intellectual disabilities are untrustworthy (Dickman, 2013). However, these perceptions of intellectual disability are largely and unjustly exacerbated by stigmatisation around the disability, including ideas about infantilisation and inability.

Where the view of women with disabilities as not credible is prevalent such abuse may be ongoing, as even though victims may try to articulate their experiences, they may not be believed. A participant who works in the disability sector explains that it takes a lot of courage and often tenacity to disclose sexual violence, and this may be an especial challenge for women with intellectual disabilities:

“They can’t fight for themselves, so if somebody tells them, you know ‘it is nonsense, go’, they will go. Where I would say, ‘but I insist on seeing your superior’ or ‘I insist on this’. They don’t do that, so a

lot of the times they’re pushed aside ... the bottom of the pile ...” (Participant 48)

Subsequently many caregivers only acknowledge abuse when they see physical symptoms, including injuries, sexually transmitted infections and pregnancy, compounding the trauma of the event. At this point it is often extremely difficult to find evidence, perpetuating the view that women with intellectual disabilities are easy targets.

*Self-stigmatisation and negative self-image*

As a result of the slew of myths, negative attitudes and stereotypes that they are subject to, individuals with intellectual disabilities often internalise negative perceptions of themselves, developing a poor self-image and feelings of inadequacy and rejection, and ultimately stigmatise themselves just as the rest of society does (Dagnan and Waring, 2004). On a daily basis people with intellectual disabilities operate from a point of relative disadvantage, continually having to withstand other people’s prejudices, and to cope with their own negative self-image and fears of rejection:

“They always think that, I wonder where I’m going, am I going to be accepted? That’s the first question when you going out that door... am I going to be accepted because people, they just looking down at you.” (Participant 52)

When GBV and disability coincide, help-seeking behaviour may be extremely poor. Given the multiple oppressions that they face as part of their experience as a person with a disability, women often see “violations of their rights as part of the package of being disabled” (Participant 6). In addition to being traumatised by what has happened, they themselves may believe that they deserve to be victimised in the first place, that they do not deserve help or that they will not get help should they ask for it. As one participant, the head of a disability organisation, explains:

“I think it is one of the most horrific things because I think the majority of people with disability have this feeling of inadequacy and uselessness or whatever and now it’s compounded. So my self-worth has just gone down the drain.” (Participant 50)

In general women who have been systematically abused are often conditioned by the perpetrator to doubt themselves, and suffer from very low self-esteem. As a result they do not believe that anyone will want to help them should they ask, and feel that they do not deserve help. With women with disabilities this can be even more severe, where the perpetrator often capitalises on existing fears and insecurities by framing himself as credible and the victim as not (Milberger *et al*, 2003; Rosen, 2006). One participant gives an example of what a perpetrator might say to a victim: "They're not going to believe you. You're mad and I'm an upstanding citizen" (Participant 57).

The feeling that seeking help is futile can be compounded when help is not forthcoming, or when appropriate services are not easily accessible:

"Even if you do refer them to these people who will actually help them, they find like you didn't assist them. They don't take the fact that, OK, for the fact that you refer them to somebody else, that's where they going to get help. They just think 'You didn't help me as well, how am I going to get help elsewhere?' So there is low self-esteem." (Participant 37)

As a result of pervasive and complex stigma, many people living with intellectual disabilities often face alienation and isolation within their homes, communities and workplaces. This makes them easy targets for GBV, as they are already seen as inconsequential or undesirable, and may not have the support needed to buttress them against victimisation or to successfully report such victimisation to family, caregivers and friends (Andrews and Veronen, 1993; Bryen, 2014). Furthermore, they are likely to suffer repeated victimisation over long periods of time, due to the complex stigma associated with disability, compounded by the further erosion of confidence and trauma associated with abuse.

## Conclusion

From the interviews with service providers in the disability sector and in the GBV sector who work with women with intellectual disabilities, it is apparent that the experiences of women

with intellectual disabilities, including their vulnerability to and experiences of violence, are mediated by multiple, complex social perceptions and myths. These myths do not each operate in isolation but interact with each other, and wider social attitudes, in complex and detrimental ways. All women are vulnerable to violence and abuse. However, the stigma and social isolation that characterises the experiences of women with intellectual disabilities serves to isolate such women as targets for violence and to reduce women's personal and social protective factors.

For example, whilst some women with intellectual disabilities are blocked from information about sexuality and GBV by their caregivers, they exist in a social context that may also see them as sexually deviant or 'hyper-sexed', and that is extremely misogynistic and violent. As a result, such a woman may be more likely to be targeted for violence, less likely to be able to identify and react to such violence, less likely to report such violence, and less likely to be believed when she tries to report such violence. The complex nature of stigmatisation points to two significant gaps, outlined below.

### ***The need for more research on GBV against people with disabilities***

At present there is little research that illuminates the scale and nature of violence against women with intellectual disabilities globally, and no research in South Africa. Only through continued and expanded research can we capture the effects of pervasive and complex stigma around women with intellectual disabilities and its relationship to GBV. In addition, the profile of prospective perpetrators needs to be better understood, in order to corroborate the perspectives expressed by service providers – that perpetrators' perceptions about the sexuality of women with disabilities as well as their credibility impacts on their victimisation. In addition, evidence in the United States suggests that partners are the most likely perpetrators against women with disabilities (Hanass-Hancock, 2009). Participants in this study suggested that in the cases that they had encountered, perpetrators were family members, peers in a school or residence, community members or strangers.



## ***The need for education and awareness on the intersection of disability and GBV***

Existing strategies to combat violence against women do not adequately engage with the stigmatisation of women with intellectual disabilities, and their related vulnerabilities. Mainstream awareness and advocacy programmes seldom focus on women with disabilities, least of all intellectual disabilities, further rendering them invisible. Efforts should include education for women and girls with intellectual disabilities that focus on sexuality, relationships and GBV; public education to dispel myths and stigma about women with intellectual disabilities and GBV; and training of service providers at all levels of the social development, public health and criminal justice systems to dispel stigma and recognise and react to the vulnerability of women with intellectual disabilities.

### **Note**

1. As far as could be established, police crime statistics on rape, domestic violence and other offences relating to GBV are not at present disaggregated to indicate whether the victim (or perpetrator) was a person with a disability.

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TALIA MEER is a researcher at the Gender Health and Justice Research Unit, and doctoral candidate in the Department of Sociology at the University of Cape Town. Her work at the Unit has involved women's incarceration, gender mainstreaming in African governance, access to justice for women with disabilities, and violence prevention in schools. Her research interests include: Gender, gender-based violence, disability rights, LGBTI rights, access to justice, and gender and education. Email: [talia.meer@uct.ac.za](mailto:talia.meer@uct.ac.za)



HELENE COMBRINCK is currently an Associate Professor in law at North-West University. She previously worked as a senior researcher at the Centre for Disability Law and Policy at the University of the Western Cape. Prior to this she coordinated the Gender Project at the Community Law Centre, also at the University of the Western Cape. She has published in the areas of gender rights and disability rights. Email: [helene.combrinck@nwu.ac.za](mailto:helene.combrinck@nwu.ac.za)