AG AboutGender
International journal of gender studies

https://riviste.unige.it/aboutgender

DOI: 10.15167/2279-5057/AG2020.9.18.1190

Vol. 9 N° 18 anno 2020
pp. 1-22

Canadian Social Workers' Understanding of the Complexities Involved with the Intersections of Women, Disability and Intimate Partner Violence

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Abstract

The aim of this investigation was to gain insight into Canadian social workers' perspectives and practice contexts in relation to disabled women who had experienced intimate partner violence. Social workers were interviewed about their work with disabled women who had experienced partner violence. Findings showed inconsistencies in the services that were offered to disabled women, depending on the setting and social workers' knowledge or willingness to circumvent government social policies. Social workers' practice contexts were complex and reflected the unique needs of disabled women who had experienced intimate partner violence, social workers' attitudes, work settings and resources.

Keywords: disabled women, Canadian social work policy, intersections, partner violence.

1. Introduction

Canadian social workers have engaged with disabled women in a variety of settings including healthcare, child and family services, women's shelters, private practices, schools and crisis shelters (Heffernan, Blythe, and Nicolson 2012; Oliver, Sapey, and Thomas 2012; Xun 2019). Certain barriers can make it more difficult for professional social workers, to identify disabled women's experiences of Intimate Partner Violence (IPV), even though they are two to five times more likely to be abused than non-disabled women (Burlock 2017; Ruiz-Perez, Pastor-Moreno, Escriba-Aguir, and Maroto-Navarro 2018; Schrottle, and Glammeier 2013). Saletti-Cuesta, Aizenberg, and Ricci-Cabello (2018) found that barriers to address violence against disabled women included organizational factors and professionals' perceived roles and attitudes about IPV. Nixon (2009) argued that a narrow understanding of disabled women could play a role in how the dynamics of violence are recognized. For example, if professionals perceive disabled women as passive, asexual and not having intimate partners, they may minimize or overlook disabled women's IPV experiences (DAWN 2014; Nixon 2009; World Health Organization 2011). There is also evidence to suggest that social workers often lack specialized training or education to help them recognize complex instances of IPV (Heffernan *et al.* 2012; Oliver *et al.* 2012). This lack of awareness is an indication that social workers could be missing opportunities to meet disabled women's needs (Oliver *et al.* 2012).

Over 50% of disabled women are likely to have experienced IPV compared to non-disabled women (Statistics Canada 2014). Women with cognitive or sensory disabilities are at a higher risk for abuse because "…society believes that no one would sexually assault a woman [who is] viewed as having no sexuality…" (DAWN 2013, 3). Disabled women are more likely to experience IPV, if they have been in a long-term intimate relationship, are older, poor, or Aboriginal and if they have a male partner who is also a caregiver and abuses alcohol (Brownridge 2006; Hahn, McCormick, and Silverman 2014). DAWN (2014) found that even though disabled women's right to self-determination has been improving in Canada, barriers such as having difficulty in making contact with shelters, a lack of accessible information, transportation and housing and the fear of not being believed by authorities meant that disabled women were hesitant in reporting their experiences of IPV.

Disabled women's experiences of IPV are more complex than non-disabled women and can vary depending on their particular disability, race, social class, ethnicity, culture, history and geographic location (Mays 2007). IPV typically includes physical, psychological, emotional, financial, and/or sexual abuse but for disabled women, it may also involve the manipulation of medication or mobility aids, neglect, destruction of mobility or communication devices, denial of essential personal care, isolation and threats of institutionalization or the removal of their children (Breiding, and Armour 2015; Orke, Vatnar, and Bjorkly 2018; Powers *et al.* 2009). These threats may discourage them from reporting abuses and could explain disabled women's prolonged exposure to IPV (Hassouneh-Phillips, and McNeff 2005).

To this end, few studies have examined social workers' perspectives and their work with disabled women who have experienced IPV. When there is a gap in research and practice evidence, this may lead to less than ideal service experiences, because social workers may be lacking crucial information needed to deliver meaningful support and assistance to disabled women who are experiencing IPV.

2. The aim

The aim of this investigation was to understand Canadian social workers' perspectives and practice contexts in relation to disabled women who had experienced IPV. It is important to note that there is no universal agreement on how to define disability, yet how social workers understand disability and IPV can affect the services that disabled women receive (Thiara *et al.* 2012). For example, social workers who focus on the medicalized view of disability are likely to see disabled people as being ill and emphasize services users' limitations (Dunn, and Langdon 2016). The medical model or individual model define disability in terms of individual deficiencies while the alternative, the social model implies that discrimination against disabled people, is rooted in dominant cultural perceptions, social oppression and the environment (Oliver *et al.* 2012). When social workers apply solutions that are based on a medicalized framework, they may be focusing on the individual's impairment and miss identifying instances of IPV. Indeed, women and a greater number of disabled women are more likely to be have been abused by their male partners, than men abused by their female partners (Mays 2007; Ontario Women's Justice Network 2013). That said, if social workers' approaches were based on the social or anti-oppression models, they would also focus on addressing barriers that impede disabled women's abilities to leave abusive relationships.

On one hand, in order to improve upon social workers' ability to meet the needs of disabled women who have experienced IPV, it is essential to recognize that external factors such as accessibility issues, the lack of resources and government cut backs also play a role in the restriction of social workers' practices (Galambos 2004). For instance, hospital social workers who were asked to facilitate the discharge of patients were faced with additional challenges because there was a lack of community services, not enough accessible housing and a long waiting list for the next level of care (Redfern, Burton, Lonne, and Seiffert 2016).

On the other hand, Westhues and Wharf (2012) stated that social workers have some discretion in the way they interpret and administer social policies that affect service users. These same authors suggested that a way forward would be to understand how social workers interpret policies, because their interpretations affect how they relate to service users and often determine the future course of their lives. That is to say, if a social worker fails to recognize a disabled woman's experience of IPV, she may not be provided with access to social services that could have helped her to leave the abusive relationship. This current study is significant as it examined social workers' perspectives and practice contexts in relation to disabled women who had experienced IPV and identified gaps that could affect how social services are offered to disabled women.

3. Methodology

While some researchers might have chosen focus groups, that typically include a diverse number of participants and a directed conversation on a topic in question, given that this study was interested in social workers' experiences, perspectives and practice contexts with disabled women who had experienced IPV, semi-structured interviews with a Canadian sample of social workers were considered to be the most appropriate qualitative methodology, to address the research questions. Ferguson (2016) agreed that interviews with social workers and less often with services users have been favored when investigating social work practice. In addition, several research studies found that disabled women no longer wanted to be consulted for their views and ideas by researchers and policy makers instead, disabled women wanted to be able to see concrete actions; for this reason, the focus of this study remained on social workers (Rajan 2011; Vecova Centre for Disability Services and Research 2011).

A critical disability approach is the theoretical approach that influenced this research. Critical disability theory attempts to identify the differences that maintain the hierarchies between disabled and non-disabled people (Vehmas, and Watson 2014). One example is that disabled people are perceived as being less capable and non-sexual when, in reality, it is the inaccessible environment and stigmatizing attitudes from mainstream society that are dis-abling (Shakespeare 2006). In light of this, it was important to determine how Canadian social workers perceived disabled women to see if their attitudes would be reflected in how they delivered services. The authors were curious to find out, if social workers' definitions of disability would be in line with the social model that views disability as being located in the environment or if their definitions of disability reflected a more medicalized view of disability, that it is an individual deficit. After all, the participants' understanding and definitions of disability could have influenced how they related to disabled women and how they met their needs (Westhues, and Wharf 2012).

The first author is a social worker who has worked in the field for over 10 years and her practice has included disabled women who had experienced IPV. Research ethics approval was obtained and a request for social workers to participate in this qualitative research inquiry was sent by email, across Canada, to various Canadian Social Work associations, disability organizations, and university deans of Social Work. Social workers who wanted to participate returned their consent form and contact information to the first author by email.

Ten Canadian social workers who had worked with disabled women who had experienced IPV participated in audio-recorded semi-structured interviews, either face-to-face, or out of province social workers participated by long-distance audio-recorded telephone interviews. Each social worker received a ten-dollar gift card by email for participating. Participants were interviewed in their places of work, at home, or at a university location, at a time of their choosing. Participants were asked a series of open-ended questions that examined how they perceived and defined disability and intimate partner violence, as their understanding could have influenced how they addressed disabled women's needs. Participants were also asked to describe how government legislation or policies had influenced their work and to talk about any barriers or resources they had encountered in their practices with disabled women who had experienced IPV.

Participants were assigned a fictitious name for the purposes of confidentiality. To ensure the quality of this study, accuracy was achieved with the use of process notes throughout the inquiry. Note writing was a way to be reflexive, minimize biases and to ensure consistency when conducting the interviews (e.g., asking the same questions in the same order). Audio-recorded interviews lasted between 60 and 120 minutes, were transcribed verbatim and generated over 200 pages of transcripts. A thematic analysis was conducted and after reading and re-reading the text multiple times, initial categories were identified. Continually comparing the initial categories to each other led to the emergence of secondary categories. Final categories were merged into themes that reflected the responses to the interview questions. Inter-rater reliability was achieved by a having a second reviewer examine the transcripts to ensure that all the contextual information had been taken into account and tabulated. This process showed that the major themes identified were consistent with the initial review of the data.

4. Findings

In this study, ten social workers, nine women and one man who had worked with disabled women who had experienced IPV were interviewed. Participants were from the Canadian provinces of Prince Edward Island, Nova Scotia, Ontario, Saskatchewan and Manitoba; five were practicing in rural areas and five had current or previous practices in a city. Participants were 26 to 65 years of age, non-disabled Caucasian, the average being 52 years and several social workers worked in more than one field of social work practice (Table 1).

Participants had been working as social workers for about 20 years and 19 of these years were spent working specifically with disabled women who had experienced IPV. The majority of social workers who were interviewed had a Master of Social Work degree, two participants had received some training in partner violence, four participants said they had received training in disability and one social worker said that he had received mental health sensitivity training at work. Five participants specified they had taken a university social work course that included content on disability or IPV issues.

Employment Setting	*Participants N = 10*
Healthcare Services	4
Child and Family Services	3
Women’s Shelter	2
Private Practice	3
Mental Health Services	2
Secondary Housing	1
Community Living	1
Addictions Program	1

Note. Participants worked in more than one field

Table 1. Characteristics of Social Workers’ Employment

5. Themes

5.1. Institutional power over the definition of disability and policies affecting access to services

Social workers often work in hospitals and are expected to abide by the institutions' policies when it comes to delivering services to disabled women. In some cases, social workers had to get a physician to define and confirm disabled women's impairments. Disabled women were denied services when they could not be easily labelled. Alex said that:

> There was an example of [having] to jump through hoops… to get certain people to sign off. Doctors or whoever, someone had to say [that you had] something in order to make, it real. In a medical setting, everything is medicalized and people are often described in a certain way, [by individual limitations].

Taylor added that:

> It was the way that the institution perceived, handled and treated individuals there. That was a problem. You didn't honor the person's strengths and [you tended to] look at all the weaknesses. One thing that struck me here was how they expected people to fit in a certain box and if you didn't meet those criteria then you weren't treated.

Being denied services meant that professionals had not met the needs of disabled women. In this medicalized environment, disabled women's agency was hindered and social workers could not provide services or had difficulty accessing services for disabled women who had experienced IPV, when they had not received a diagnosis from a medical professional. Arstein-Kerslake (2019) found that governments or institutions often ascribed labels and qualities to certain groups of people without making distinctions between individuals. This practice is disempowering to individuals like disabled women and results in increased vulnerability, as opposed to supporting their rights to self-determination. Most participants said that institutional policies restricted how they could assist disabled women who had experienced IPV while, two social workers described having to find ways around to accommodate disabled women. Kelly emphasized that he was discouraged by the Health Authority to go visit disabled women when they were in-patients; however, he said that social workers tended to ignore this policy and go anyway:

> We were strongly discouraged to see disabled [women] who were in-patients but made exceptions to that. Kelly said the reason for that policy was to prevent [social workers] from being overwhelmed with hospital requests.

Riley talked about finding ways to circumvent policies that were not helpful to disabled women who had experienced IPV. She said that:

> A lot of these policies were restrictive [and determined] who could get the help and who couldn't [because of] how they defined their disability. The medical field I felt… was strictly based on impairment, so focused on what a person could not do whereas, we tried to flip it around…we tried to focus on what a person could do.

Mackenzie explained that disabled people would not be defined as disabled, if their environments had accommodated their needs, she went on to say:

> Disability [is] defining people as not being able to manage within the world that we have set up and there's no recognition that we've set up the world that way, according to our needs. If the world was set up differently, by different people, then they wouldn't appear to be disabled, they would just appear to be navigating the world, because it's been set up to facilitate their life, their participation.

5.2. Recognizing partner violence complexities

The majority of social workers in this study were familiar with the type of partner violence that non-disabled women experience but few could identify instances when disabled women experienced more complex types of abuse. An exception was Jesse who talked about a disabled woman, she said:

> Her partner who was also her caregiver delayed things or he did not do things right away. If she needed to move from say, the wheelchair to the bed, he would say ‘well we’ll do this more at my leisure, so not when you need it’.
> I mean if you depend on your partner to take you to the bathroom or wheel you from here to there, to get you to appointments you know, you’re more dependent.

5.3. Failures to meet the needs of disabled women

Participants went on to describe other instances when systems and professionals had failed to meet the needs of disabled women. Social workers felt challenged when trying to obtain financial assistance, housing and work for disabled women who had experienced IPV.

Avery recalled how it was almost impossible to obtain financial assistance from the Government for one disabled woman, who was determined and wanted to make her home accessible:

> Let’s say someone had limited income and they were looking for a government program for help, to do renovations or something that needed to be done to upgrade their home or those kinds of things. You had to physically not be able to get into your house or [be] financially limited [to get even minimal help].

Mackenzie pointed out the absurdity of having a priority housing list for disabled women who were poor and had experienced partner violence, when there was very little accessible housing available. She said:

> Unfortunately, if you’re on top of a list that doesn’t move, it doesn’t really matter does it? There’s no movement, which is often the case for housing.

Social workers also cited communication difficulties between various government agencies and their negative impact on disabled women’s services. Government agencies were operating in individual silos, instead of working together, services could have been ameliorated by improving communication between various agencies. Jesse said:

> I mean it's even difficult to get two branches of the same department of the Government to talk to each other, like Income Support and Child Protection. [These] used to be housed under one unit… here and now it becomes a mission to even get them across the table from each other.

Alex gave an example of:

> A disabled woman whose kids [were] in involuntary care and she'd been abused. Income support didn't want to pay for her to have a larger place until she got her kids back [but] child protection wouldn't give her kids back until she got a larger place, so we had to step in.

5.4. Attitudinal barriers

Three participants were struck by other professionals' negative attitudes and their lack of understanding concerning issues related to disability and partner violence. Kelly said that women's shelters were usually a good resource that accommodated disabled women however, there was one instance he described where this was not the case, he said:

> Women's shelters, I found them to be quite welcoming of people, although I make that statement, but there was one woman who had schizophrenia and she went there… They thought that she wasn't stable… I disagreed and I called and tried to intervene on her behalf, but to no avail, and they asked her to leave.

A similar lack of empathy and understanding was conveyed by Riley, who recalled one rural physician's harsh comments about disabled people and how this made disabled and abused women uncomfortable to go to the doctor, because he was the only one available. She said:

> The doctor would say, 'I still don't understand why we are wasting our time with these people, why are we providing care for these people'? Unfortunately, [disabled and abused women are] already isolated because of their location and they only had access to this particular family doctor because it's a rural area. There's already not a lot of services, not a lot for disability and then you have a doctor who has an attitude

> like that, then how likely is it that you will go for services? I mean he closes the door and you… feel uncomfortable.

Mackenzie was astonished by the negative attitudes that some social workers had towards disabled women who had been abused by their partners, she recalled that:

> Even the social workers [who work in the shelter], can be so jaded and when you try to challenge them on the assumptions that they are making they even justify their thinking by saying things like, 'well you know you have to understand when you've been in this field for as long as we have, you just know how cases are going to go; you just know that this person is not going to follow through and yes it's an assumption but it's based on a lot of experience'. I'm thinking you're defending this, you're defending your position, and you're making negative assumptions about people.

5.5. The context

Social workers concluded that their practices with disabled women who had experienced IPV were affected by their work settings, more specifically, that the context made a difference and could influence how they worked with disabled women. Lee felt that the workplace determined what professionals were likely to focus on when they worked with disabled individuals:

> If you worked in a hospital and you were working with physically disabled [women] it was a much different focus; it was more medicalized. I guess it was more focused on the physical and the medical.

Mackenzie talked about her rural work setting and how disabled women did not always know about the services that were available and maybe if they had known, they would have been able to make better decisions for themselves:

> A lot of disabled women didn't know that no matter where [they] were in the province that we could get them [to a women's shelter], we could provide transportation. Some may have felt that because they couldn't leave their home without assistance

> and they couldn't drive here, that they couldn't get here but that's not true. We could get them here, unfortunately they didn't know this and until they contacted us we didn't know that they wanted to [leave their violent relationships] so it's a tricky thing.

6. Discussion

A diagram based on Miles and Huberman (1994) seminal work was developed to illustrate contextual elements identified by participants. The strength of this study is anchored in elements that show the unique synergy and complexity of social workers' practices with disabled women who had experienced IPV (Fig. 1). Understanding how layers of structural factors and attitudes interact and affect the delivery of social services to disabled women could lead to uncovering new priorities and a positive way forward. For instance, Government regulations for healthcare and social services were front and centre when it came to influencing social workers' practices with disabled women who had experienced IPV.

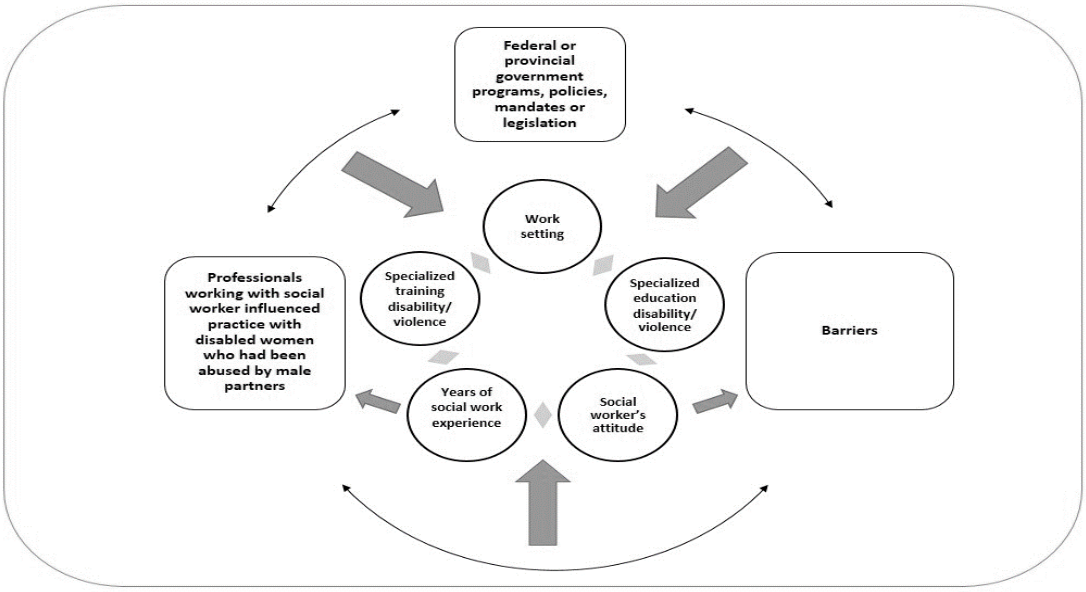

Fig. 1. Contextual Elements Identified by Social Workers

Findings showed that social workers who practiced in a healthcare setting, in developmental services and for child and family agencies used the medical definition of disability to determine disabled women's eligibility for benefits. On one hand, it may have been difficult for social workers in these settings, to avoid the medicalized view of disability as most individuals around them were likely practising according to the medical or rehabilitation models and the medicalized definition of disability was part of the criteria that was used to determine eligibility for social services. On the other hand, despite working in a healthcare setting, it became evident that some social workers were not focused on the medicalized view of disability, because their work centered on the removal of barriers that prevented disabled women from obtaining resources they needed. This finding is consistent with Westhues and Wharf (2012) that social workers have some discretion in the way they interpret and administer social policies that affect service users.

Some participants said the issue with the medical definition was that it was limited and disabled women were likely to be denied benefits when their disability was not considered sufficient enough to be granted benefits by a medical panel of professionals. This insufficiency led some participants to advocate for disabled women and to show that disabled women were entitled to receive social services.

According to provincial policies or programs in this study, disabled women had to be labelled as being unemployable (financial resources were not enough to meet basic needs) for a short (at least 90 days) or long period (indefinite) by a panel of medical professionals, in order to be considered disabled (Manitoba Disability Issues Office 2001). Fitting the disability criteria as outlined by a medical professional meant that service users could receive social services and not fitting the disability criteria meant that they would be excluded from receiving social benefits (Manitoba Disability Issues Office 2001; 2015; Seefeldt 2015). This finding was consistent across Canada.

Alternative definitions of disability were also offered by some social workers who were practicing in women's shelters, as they defined disability as being a problem with the environment or to negative attitudes. This distinction is significant because it draws attention away from the medicalization of disability and is in line with Titchkosky's (2011) interpretation of disability, that it is a problem in the environment. Acknowledging that the environment and negative attitudes are disabling to women who have experienced

IPV could lead to actionable changes such as improved policies and the removal of barriers that prevent disabled women from accessing services.

Few social workers in this study indicated that they understood the complexities that disabled women could experience in violent relationships because they did not appear to realize how disabled women's partner abuse could be unique when compared to non-disabled women's experiences of IPV. Similarly, social workers in this study did not talk about the diversity of disabled women in their practices, perhaps an indication that their practices were homogenous or that they did not recognize multiple intersections, such as ethnicity, disability and age.

Dixon and Robb (2016) intimated that social workers should challenge their own unstructured professional judgement related to disabled women's risk of partner abuse as they are likely to underestimate the prevalence of partner abuse among disabled services users. This finding also suggests that opportunities to help disabled women could be missed and that more education and supervision is required if social workers are to recognize the types of partner abuses that many disabled women with multiple intersections experience.

These findings are such that even though government and agency policies were the main influences on social workers' practices with disabled women, the practice context and professional attitudes also played a crucial role in defining disability. The evidence in this study is similar to Evans (2012) who argued that social workers' practices were not just about following formal rules and policies but also included an element of professional freedom. This is an indication that most social workers have some level of discretion in the application of systemic rules. What became increasingly clear in this current study was that social workers' attitudes and interpretation of government and agency rules resulted in what Evans (2012) described as practice inconsistencies. Social workers often found themselves in the middle; trying to respect disabled women's needs, while remaining accountable to a system that demanded efficiency and accountability, even if it meant limiting or denying services (Evans 2012).

A deeper issue that became apparent in the findings of this study was the Provincial Government's role in determining social services policies and the allocation of services in all of the provinces. For instance, social workers recognized a multitude of barriers that influenced their ability to meet the needs of disabled women, such as a lack of work, poverty, accessible transportation, housing and women's shelters. These barriers need to be addressed because findings demonstrate that provincial governments were not always invested in the provision of services and resources that could have met disabled women's needs.

All social workers said there was a lack of accessible housing and that it was more problematic in some rural areas. The lack of accessible housing meant that disabled women who had been abused by their partners had few, if any housing choices, when it came to leaving violent relationships. A revelation was that social workers reported that they were expected to follow government directives and place disabled women who had experienced IPV on a priority list for housing and for other services; however, they felt this was irrelevant due to the lack of accessible housing. Some participants reported that certain government agencies refused to work together to meet the needs of disabled women. This issue was common across all provinces in this study and typical of Child and Family Services, as well as Income Support and Housing agencies. The majority of participants argued that agencies were more efficient when they belonged to the same department, compared to being in separate departments and buildings, as some agencies tended to be today. This unique finding suggests that communication and efficiency could be improved by combining government departments.

An interesting finding is that most participants were knowledgeable about provincial polices and legislation. However, policies that are too narrow are an indication that policy makers are either unaware or unwilling to address the lack of resources. This further demonstrates how social services tended to be limited, how government directives intersected with structural barriers and in some cases, even prevented social workers from being able to meet the needs of disabled women who had experienced IPV. A related concern was raised by social workers when they spoke about women's shelters and inaccessibility. Participants said that provincial governments did have action plans concerning women and partner violence but they lacked specificity about disabled women's experiences of IPV. This meant that women's shelters might have been considered a resource but were not necessarily accessible and not all shelter staff had received specialized training or education to work with disabled women who had mental health issues. Despite their best intentions to meet the needs of disabled women in their practices, participants expressed frustration at not being able to find solutions because of structural barriers that prevented them from helping disabled women find accessible shelters, housing or work.

Participants also talked about social barriers that had affected disabled women in their practices. One particular barrier was the attitude of professionals, such as a rural physician who spoke openly about his bias and disdain of disabled people. Satchidanand *et al.*, (2012) argued that a physician's attitude towards disabled people may impact the care that is provided. When physicians have negative attitudes or a lack of knowledge about disabled people, the focus may be on the disability instead of on the person as a whole, or the overall care may be inferior compared to the care given to non-disabled people or treatment may be withheld altogether (Satchidanand *et al.* 2012).

In this study, more recent education was reported to enhance participants' knowledge as they remembered and they applied their course learnings about disability and violence issues. Formal education was not the only path that social workers had to acquire disability knowledge because mental health sensitivity training for professionals in social work, healthcare and the court systems were mentioned as a valuable educational resource.

7. Implications and Conclusion

This inquiry into 10 social workers' perspectives and practice contexts with disabled women who had experienced IPV found inconsistencies. The implication of this finding is that disabled women may have received different kinds of services depending on the situation and their social worker's knowledge or willingness to circumvent government social policies. Social workers who were more creative and knowledgeable were able to navigate the system better than social workers who were new to the profession and not as familiar with advocating for service users. This meant that some disabled women who had experienced IPV could have received social services and benefits, while others might have been denied services. One way to increase consistency could be to ensure that social policies, provincial income support programs and available resources are more in line with the needs of service users to begin with. This could be accomplished by involving social workers who work in the field, along with service users, and disability organizations in the drafting of changes to existing policies, instead of relying on inadequate social policies that are likely based on efficiency and the reduction of provincial or federal government expenditures. More precisely, provincial welfare policies have to evolve beyond the rationing of community disability services, to social welfare policies that support the needs of disabled women (Stainton, Chenoweth, and Bigby 2010). Chang *et al.* (2003) as well as Redfern *et al.* (2016) have also argued that collaborative work across systems with disability organizations is needed to improve disabled people's access to healthcare and social services.

Another finding was related to the lack of current knowledge by some social workers in women's shelters in relation to mental health issues and to more complex types of abuse that disabled women experienced. Social workers should be required to take specialized training, receive additional supervision or education in disability (such as mental health issues) and partner violence in order to understand the complexities of disabled women's experiences of IPV. It is possible that with enhanced knowledge, shelter staff and all social workers that receive appropriate training or education in the areas of both disability and partner violence would be more welcoming and understanding of disabled women with mental health issues.

A limitation of this study is the small number of participants therefore, the findings cannot be generalizable to all social workers. A more comprehensive study with a greater number of participants might provide additional evidence to support the restructuring of social services to better meet the needs of disable women who have experienced IPV.

Findings demonstrate that social workers' practice contexts are complex and reflect the uniqueness of the needs of disabled women experiencing IPV, social workers' attitudes, available resources and work settings. Additional research into social workers' perspectives and risk assessments of disabled women who have experienced IPV is required to increase harm reduction. Government policies and legislation need to be balanced to better support and fund services that will benefit disabled women who are experiencing IPV.

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