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ORIGINAL ARTICLE

Intimate partner violence in women with disabilities: perception of healthcare and attitudes of health professionals

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ABSTRACT

Purpose: Intimate partner violence (IPV) is a major social problem and public health issue, but we still have a relatively small amount of data about partner violence in women with disabilities. The main objective of this study was to understand the experiences of women with disabilities who are or have been abused by their partners and to explore the knowledge, views and training requirements of primary care professionals.

Method: Qualitative study using semi-structured interviews with women with disabilities who had experienced IPV ($n = 14$), and focus groups with healthcare professionals ($n = 16$).

Results: Women with disabilities suffer specific forms of abuse. Because they depend on the people around them to take action, they are subordinate and this can prolong the abuse. The healthcare staff frequently mentioned that it is often difficult to notice that women with disabilities are being abused. Their lack of training about disabilities and gender-based violence makes them less sure of their ability to identify and deal with any possible cases of abuse.

Conclusions: The difficulties described by the women interviewed are broadly speaking the same as those described by the healthcare professionals consulted. A number of suggestions for improvements are provided based on the results found.

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KEYWORDS

Intimate partner violence; disability; primary healthcare; women's health; qualitative research

► IMPLICATIONS FOR REHABILITATION

- The rehabilitation of abused disabled women implies that women perceive the health system as a resource to resolve their situation.
- Healthcare professionals should be trained on how to detect, treat and communicate with disabled women who experience partner violence.
- Is needed to establish a comprehensive system of coordination between services involved in caring for abused women and with disabilities.

Introduction

Our awareness of gender-based violence has grown considerably over recent years. It is widespread and has significant repercussions on the health of the women involved, so it is now recognized as a major public health issue. The healthcare sector's approach to tackling this type of violence can fail in some contexts, as certain barriers can make it difficult to detect the signs. Intimate partner violence (IPV) against women with disabilities is a unique form of abuse, in terms of both the nature of the violence itself and how it is treated. This means that IPV against women with disabilities must be tackled using a very specific approach.

According to WHO, "disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions" [1]. As a result, many of the difficulties faced by people with disabilities are not the direct result of their own impairments, rather of the obstacles or barriers that exist in their social environment.

According to European Office of Statistics (Eurostat), there are approximately 43 million women with disabilities living in European Union, representing almost 6% of the entire female

population [2]. According to the Institute for the Elderly and Social Services of Spain [3], there are 2.8 million people with disabilities in Spain, 50.1% of whom are women. Although these figures help us to understand the scale of the problem, there is practically no information specifically about women and girls with disabilities living in rural areas, or who have migrated to Spain, and who are severely affected by or victims of gender-based violence. This lack of information is due to the mistaken perception that women and girls with disabilities form part of a single, homogeneous group, with little or no understanding of the diversity and heterogeneity of that group. In addition, people with disabilities have to deal with many problems that their able-bodied counterparts do not face: barriers to education, employment, healthcare and social participation, and a lack of access to or insufficient provision of services [4]. On top of this, women with disabilities also have to deal with sexual discrimination, and may also be the victims of physical, psychological and/or sexual abuse.

A study carried out by WHO in a number of countries found that between 15% and 71% of women reported that they had

been subjected to physical or sexual violence by their partner at some point [5]. The European Parliament [6] estimates that almost 80% of women with disabilities are victims of violence. When these two factors (being a woman and having a disability) are combined, there is an extremely high risk of violence, and some studies have found that women with disabilities are at a higher risk of suffering physical and sexual abuse [6–10]. Other studies have found that the male partner is the most common abuser [8]. In addition, researchers have found that there are some forms of IPV specific to women with disabilities that do not occur amongst women without disabilities [11–13]. However, these findings are often based on highly heterogeneous sample groups of women with disabilities when, in practice, prevalence, risk factors and interventions can all vary depending on the type of disability studied [14].

The healthcare sector plays a key role in the prevention of violence. A significant number of women seek help from the health service, so healthcare professionals have a particular responsibility [15]. Interventions of any type can fail if the healthcare professional involved has not received the right training. Although the health service already has a wide range of initiatives in place to detect and tackle gender-based violence, some studies have found that healthcare professionals feel that they lack the training, time and resources they need [16]. However, we do not know what healthcare professionals think about the link between disability and IPV, or what they feel they lack when it comes to tackling these unique cases.

In short, there are a number of aspects of this public health issue that we still need to investigate. The aim of this article is to tackle our lack of knowledge in this area by giving a voice to women with disabilities who are also victims of violence, whilst also outlining the opinions of the healthcare professionals directly involved in tackling this issue. This qualitative study will give us a better understanding of the strengths and weaknesses of the primary care sector's approach to dealing with IPV in women with disabilities from the point of view of the women involved.

The objectives of this study are: (a) to understand the experiences of women with disabilities who are or have been abused by their partners or former partners; (b) to find out how abused women with disabilities perceive the healthcare they receive, and their expectations of the health services; (c) to explore the knowledge, views and training requirements of primary care professionals involved in helping these women.

Methods

A qualitative study using a phenomenological method was carried out in the Spanish autonomous region of Andalusia. The study focuses on the experiences of women with disabilities who had been victims of IPV, and on the primary healthcare professionals' experiences of tackling these cases in their places of work. The descriptive power of this approach makes it possible to study in detail the context in which phenomena, in this case IPV against women with disabilities, occur [17].

During the first stage of the study, in-depth interviews were carried out to find out about the experiences of women with disabilities who had been abused by their partner or former partner. Focus groups were then held with healthcare professionals (doctors, nurses and social workers) working at primary care centers, to find out about their knowledge of IPV against women with disabilities. Using an in-depth interview makes it possible to explore the subjectivity of the problem [18] and the focus groups allow for interaction and the exchange of ideas amongst participants.

Table 1. Participant profile (women).

Code	Disability type	Age	Level of education
E1	Deaf/partially deaf	51	Sec.
E2	Deaf/partially deaf	54	Prim.
E3	Blind/partially sighted	61	Prim.
E4	Blind/partially sighted	55	Sec.
E5	Organic	50	Prim.
E6	Physical and organic	65	Prim.
E7	Physical and organic	36	Sec.
E8	Physical and sensory	38	Sec.
E9	Physical	66	Prim.
E10	Physical	34	Prim.
E11	Mental	38	Prim.
E12	Mental	64	Sec.
E13	Physical and mental	62	Sec.
E14	Physical and mental	51	Prim.

Ethical approval was obtained from Research Ethics Committee of the Andalusian Government.

The inclusion criteria for the first part of the study (in-depth interview) were that the women were aged between 18 and 75 and were not in care. Women with psychological disorders or disabilities so severe that they could not maintain adequate levels of communication and understanding were excluded from the study. A total of 14 women of different ages and levels of education, with various different types of disability, were included in the study (Table 1). The participants were intentionally selected and approached via professionals linked to different support and healthcare organizations for people with disabilities and victims of gender-based violence. The principal investigator contacted the relevant person at each organization and sent a letter detailing the profiles of the women required for the study. These profiles were based on segmentation criteria designed for the sample group: type of disability (physical, psychosocial, cognitive or sensory), age (under 50 or over 50 years of age) and level of education (primary or secondary). These informants played a key role, pre-selecting the participants based on a series of criteria, then approaching them and providing them with information about the study and their role in it should they choose to take part. Later, a member of the research team would contact the selected participants and arrange a date and venue for the interview.

A semi-structured interview script was written in accordance with the study aims and used to gather information from participants. Each interview was adapted based on the communication dynamic established between the interviewer and the participant. Five professionals working in services for people with disabilities with a gender perspective were consulted before the script was written. The information provided by these experts was used to define the scope of the interviews with the participants. In the end, the interviews focused on the women's experiences of abuse (e.g., What type of violence have you experienced? How do you think your disability influenced the fact that you experienced violence? And what influence did it have when you sought help?), their perceptions of the support provided by the health services (e.g., Did you go to any healthcare facility for problems derived from the violence? Did you tell, or intend to tell, a healthcare professional about the problem? If so, how would you rate the treatment you received? How would you rate the information and advice you were given?), and suggestions for improvements to the health service (e.g., Do you think that the institutions or services you have used take your problem, or that of other people with a similar problem, into account sufficiently? What could they do to help you more?). Fourteen women aged between 34 and 66 years, with different types of disability, took part in the study.

Table 2. Participant profile (healthcare professionals).

Group 1 (with training in gender-based violence)	Group 2 (without training in gender-based violence)
E1: Nursing	E1: Nursing
E2: Nursing	E2: Medicine
E3: Medicine	E3: Midwifery
E4: Midwifery	E4: Midwifery
E5: Social work	E5: Social work
E6: Midwifery	E6: Social work
E7: Midwifery	E7: Nursing
E8: Social work	E8: Medicine

The interviews were carried out in Andalusia in 2011. All of the participants were informed that their data would remain confidential and were required to sign an informed consent form. The interviews were held in a neutral space, taking into account the participants' preference that they be carried out in an easily accessible and comfortable environment, making them feel safe so as to avoid any bias caused by the setting. The interviews lasted an average of between 45 and 60 min, and the participants all gave permission for audio recordings to be made. Some of the participants were deaf, and in these cases a sign language interpreter provided a translation of the interview which was then recorded.

During the second stage of the study, two focus groups were held with primary care professionals. Sixteen participants with different professional profiles (4 nurses, 5 midwives and 4 social workers) were asked to take part, and the main defining variable chosen for arranging the groups was whether or not they had already received training in gender-based violence (Table 2). The script for the focus groups focused on the professionals' experiences caring for women with disabilities who had been abused by their partner or former partner (e.g., What do you know about women with disabilities? What do you know about their healthcare needs? Are they different from those of other women? What about in relation to IPV? Are women with disabilities different from those without disabilities? What difficulties does this specific problem pose in your work?). The focus groups lasted between 60 and 90 min.

Complete transcripts of the interviews and focus groups were made, and any personal details were replaced with a reference number so as to guarantee the anonymity of participants. The information from the interviews and focus groups was analyzed following the method proposed by Miles and Huberman [19]: data reduction, data display, and drawing and verifying conclusions. First, all of the material generated (transcripts, field notes) was read. The central themes were identified and coded. Open coding was used initially, followed by more detailed categorical coding. Two members of the research team each coded the information separately, and also discussed and agreed upon the emerging themes and the coding system. The central themes were re-ordered by concept and further context was provided by data from the interviews and focus groups. This made it possible to analyze and integrate a large volume of data, as well as generate ideas and interpretations. A cross analysis was then conducted with the aim of establishing links between the information provided by the women and that provided by healthcare staff, in order to complement the results obtained.

Results

The first part of this section provides the results of the interviews held with women with disabilities, exploring their experiences of

violence and their opinion of the help they received from the health service.

Other forms of violence: disability-based abuse

The violence that women with disabilities suffer at the hands of their partners or former partners is sometimes similar to the violence suffered by women without disabilities. They are experiences marked by psychological, physical and economic abuse, sexual violence and even a failure to meet family obligations.

E6: All of the money was for him, he didn't give me money. He might give me 3 EUR for the week. I couldn't buy clothes. I dressed my children with what people gave to me and I dressed myself with what people gave to me. And the little bit he gave me, well it was for food.

However, lots of other cases involve specific forms of violence, as some disabilities have been used by abusers to injure or verbally abuse women. For example, deafness or blindness have been used to humiliate women.

E1: If we went out he would say "speak up, she's deaf", and although I have quite a severe disability, people don't notice because I can lip read.

E4: He used to take my glasses and hide them so I couldn't leave the house, because I couldn't go out without my glasses. Because I couldn't see.

Abusers use disabilities to hurt their victims, and to increase their dependence and isolation.

E9: He used to threaten me. "Go to a lawyer! Report me! Report me! You're useless! What are going to do? What are you going to do, work as a cleaner? How ...?"

E10: It was a constant insult, that I was worthless who was going to love me with my hands, with my leg?

One key type of violence against women with disabilities is neglect.

E6: He used to help me do things, he'd feed my son, clean the dishes, make the beds for me, but as soon as I was unwell he'd leave and help his mother, and he'd leave me on my own.

Violence in situations of "absolute dependence"

Violence often starts where women have a traditional idea of romance and how relationships should be, believing that the partners they choose will be their partners for the *rest of their lives*, making it almost impossible for them to leave their abusers. Other key elements include lack of independence, economic dependence and, in many of the cases analyzed, a lack of social support (family, friends, neighbours) to help find a solution to the abuse.

E14: He was the one who earned money and brought money home, so I had to stick it out.

These women often respond to the violence in similar ways. First, they start to feel more and more guilty, and because they depend on the people around them to take action, they are subordinate and this can prolong the violence. Furthermore, if the services available are not adapted to their needs, they are prevented from accessing the resources that could help them break away from the violence.

E1: I couldn't call, I couldn't get access to any services and if I did they would talk to me and I wouldn't understand, I think that it's more difficult for deaf people, because the barrier we face is communication.

Healthcare services are not adapted to their needs

The attitude of healthcare professionals plays a key role in the way in which gender-based violence is managed. An active attitude, i.e., detecting the case and referring it to the relevant services, helps speed up the break-up and makes the woman feel safe enough to carry on. This sort of attitude is highly valued by the women who took part in this study. However, indifference on the part of healthcare staff can lead to women losing faith in the healthcare system.

E14: The doctor didn't do anything, and that was a big mistake. That shouldn't be allowed in a hospital, because you're seeing someone and you're seeing that she's lying to you.

When healthcare staff do not take a woman's disability into account, the care she is given will be neither complete nor effective. They feel that the care they receive dehumanizes them. Productivity and service standards take priority over the needs of patients. Furthermore, the quality of care received depends, in some cases, on the member of staff involved, almost as if luck were the determining factor when it comes to completeness of care.

E4: You go to any service, social services or the health service, and there's a work mechanism in place which means that they don't notice anything. There's a process where they don't take anyone's disability into account.

E7: If the professional is an understanding person, who acts naturally but who understands your situation, who acts differently, helps you, it makes you feel good. When the professional isn't very used to it, it's as if the wheelchair really puts them off. You feel like the person sitting opposite you isn't acting naturally.

According to the women who took part in this study, in order for care to be improved, the professionals involved in all stages of the process must be provided with training. This training would help make staff in the health service, social services and courts more aware of what these women need. The women also feel that there are not enough healthcare staff, specifically psychologists and social workers, as their waiting lists are very long and the process takes forever.

E4: So that that person is able to understand all the needs that these people can bring to them, on top of all the regulations. And to do this, either these jobs have to be given to women who have been through certain situations, or there have to be courses on gender-based violence.

Another of the most frequent suggestions was that the health service should provide information to women at risk of abuse. By providing women with disabilities with information about relationships they will understand what a healthy relationship should be like. The information they are given could be adapted depending on the type of disability that each woman has.

E11: Because I don't really know what abuse is. He says that calling me stupid isn't abuse.

It is absolutely essential that deaf women be provided with interpreters by the health service, but also by the police, the courts, etc.

E2: There has to be a 24-hour interpreting service for all of these services, in hospitals, in courts. That's the resource [we need], the only thing we need is an interpreter for these cases.

The next section describes the results of the focus groups with healthcare staff.

Specific factors that make it difficult to detect violence

The discussion of the healthcare staff consulted have some shared characteristics, whether those staff have specific training relating to gender-based violence or not. One of the most frequently mentioned problems is that it is often difficult to notice that women with disabilities are being abused, because they and the circumstances in which they are living are usually invisible.

E4-DG1: Abuse is much more hidden amongst women with disabilities. Much more hidden. There are lots more problems with it coming to light.

E6-DG2: We're talking about disabilities. About people with a severe disability. And it makes interventions more complex, much more complex. It's hard enough for any woman to wake up to the fact that she is being abused. And when you add a problem like this, and in this case I'm talking about an intellectual problem, well it makes it much worse.

Healthcare staff have noticed a clear lack of autonomy and low self-esteem amongst abused women, whether they have a disability or not. However, they also say that there are a number of characteristics specific to abused women with disabilities: vulnerability, dependence, isolation and overprotection. They also believe that there are many more factors that maintain abuse in this population group.

E1-DG1: If an abusive relationship often carries on because of economic or emotional dependence, for a disabled woman who will certainly have fewer opportunities when it comes to getting a job, or being trained, well she's even less likely to decide to end an abusive relationship, isn't she?

E7-DG1: If an abusive relationship needs isolation, that's what a woman with a disability is: isolated. So you're giving it the perfect breeding ground.

Healthcare professionals who have received training relating to gender-based violence make a key point when it comes to analyzing the abuse of women with disabilities: they suffer from two types of discrimination. First, they are women, and second, they have a disability, which puts them on an unequal footing within their family. The healthcare staff without specific training in this area are also aware of this, but they refer to it as a "double handicap".

E8-DG1: I think that these people have to deal with two types of discrimination. They are women, and on top of that they have some kind of disability.

E8-DG2: Disabled women have a dual risk. Because they are women, and because they are disabled. Because it's often easier to abuse a disabled person if that person is a woman than if it's a man, so they have a double handicap, don't they?

Unsolvable conflicts and lack of training

A number of drawbacks were brought up by the healthcare staff consulted. First of all, their lack of training about disabilities and gender-based violence makes them less sure of their ability to identify and deal with any possible cases of abuse, and the care they give to these patients. As a result of this lack of training, healthcare staff may see women with a mental disability as less credible than other women.

E3-DG1: We don't have specific training. Training that teaches us a clear method for treating these people, who have some kind of disability. And very simple disabilities like hearing loss. In other words, a deaf person in a clinic is an unsolvable problem.

E9-DG2: I don't feel that I'm able to deal with that problem. I've not been trained or prepared to deal with it. I'd find someone to solve the problem for me. I'd refer it on quickly, of course.

They therefore believe that comprehensive specialist training is a priority, as this training would not only give them the sensitivity, confidence and skills required to detect and deal with these cases, it would also give them the tools they need to optimize the time they spend with, and care they give to, abuse victims. It would also avoid the risk of using a paternalistic approach to their care.

E8-DG2: Well that's what I think, that we need training in psychotherapy, but we also need more training about sexual problems, how to deal with them, how to follow them up. I think that would be good too. And there should also be better links with other services and other things.

However, no matter how much training they have had on gender-based violence, they still see some challenges, like detecting and dealing with the violence itself or creating an environment where patients feel at ease. Most of the professionals consulted talked about the complexity of situations where the carer is also the abusive partner, and the tension that this can generate.

E3-DG1: And when it comes to you intervening you don't have a choice. Because the person who is abusing her is always with her. So you can't ask questions. It has to be something physical, violent, for you to be able to intervene.

In addition, they said that there are not enough resources available for disabled women who are being abused.

E3-DG1: I have fewer tools which I can use to help her. I've got nothing to offer her. So, I can say "Bless you, you are an abused woman, but deal with it as best you can. Because I can't do anything with you. I've got no resources to offer you." I've got very, very few resources.

E4-DG2: If resources are scarce for what we could call "normal" healthcare, then for gender-based violence, and in women with disabilities, they're not scarce, they're non-existent.

Joint solutions for a social issue

The solutions proposed for the problems identified by the different professionals consulted include time, knowledge, collaboration with associations, and raising awareness of gender-based violence and disabilities.

E8-DG1: I'd like to bring up associations again, as they're the ones who really know these groups. Especially because they have worked a lot with women and they are the ones who should be there when it comes to doing things, giving their opinion.

E6-DG2: There should be much stronger links between the health service and these private associations, so that they can share experiences and knowledge.

The professionals with training also suggest that there should be a register for disabilities and possible abuse, to make it easier to help these women, and to guarantee the statistical validity of data. The group of professionals without gender-based violence training have a similar idea. They think that recording the type and level of disability in patients' medical records would make it easier to meet their needs when they come to see them.

E9-DG2: When someone makes an appointment, there should be a system in place so that they can say that I have this or that disability, that I need an interpreter, or more time, or more staff. That would mean that the appointment would be seen as different from a normal one.

Staff without training on gender-based violence believe that there should be specific criteria for detecting that women with disabilities are being abused by their partners, to ensure that

healthcare staff intervene correctly and consistently. They also suggest that a work plan should be drawn up with the abuser.

E8-DG2: It should be easier to use a joint approach. It's not easy for you to find out about all the tricky bits of the law or all the people who are involved, so perhaps here it would also be good if there were better links between the different services.

Discussion

The results of this study give us a better understanding of two different aspects of gender-based violence against women with disabilities in Andalusia. First, they give us an insight into the experience of the women themselves, and second, they help us to understand the difficulties and limitations faced by primary care staff when it comes to detecting and dealing with these cases.

One of the key findings of this study is that the combination of having a disability and being abused puts these women in a very unsafe situation. As Plummer and Findley [13] suggest, IPV against disabled women takes on different forms to IPV against non-disabled women. Furthermore, although disabled women face the same barriers as any other woman when it comes to escaping the violence, they also have to deal with other obstacles that affect them specifically. For example, they are often trapped at home in a domestic setting that makes them very vulnerable to violence. As such, they are abused by their partner or former partner in a context of "absolute dependence", which means that they need the person who abuses them to be there [20].

Expert advice from, and conversations with, healthcare staff help women start the break-up process. However, the women who took part in this study do not feel that the health system is a good enough resource for escaping abuse. Although the healthcare staff intervene in many cases, the quality of care received is, in many cases, a matter of luck. This study has also revealed that women who are abused need to talk to someone, but as some of the professionals who took part point out, "the unknown makes [you] feel uncomfortable", and there is some uncertainty when it comes to detecting and dealing with abuse. This uncertainty may be linked to the persistent prejudice against women with disabilities, who are seen as asexual and should not have children, or unable to make decisions [21]. Additionally, the abuser is often present during appointments, making it difficult to broach the subject.

Although generally speaking all of the professionals consulted find it hard to detect abuse, those who had received training about gender-based violence use a series of concepts to back up their stance or argument. As a result, the way in which cases of abuse are dealt with during appointments is influenced by the member of staff's awareness of and training in this area. Although training on how to detect and deal with gender-based violence is starting to become common in the primary care sector, the specifics of the different types of disability pose a series of dilemmas for healthcare staff. As García-Moreno [16] states, knowing what the best course of action will be depends on each context and on the resources available (human, financial and social resources). One possible strategy and one that is widely accepted by the healthcare professionals who took part in this study, is to compile a series of specific criteria for detecting abuse, working in collaboration with other bodies and organizations: basically, to establish a system of coordination between all the services involved in caring for abused women and women with disabilities.

Furthermore, the ways in which information is disseminated should be reviewed, to make it more accessible to women with a disability of any type or severity. The usual methods of dealing

with gender-based violence also need to incorporate measures that include women with disabilities too, ensuring that they can access programs and services by providing transport or support services or sign language interpreters, amongst other things.

Finally, many of these specific forms of abuse are generally not detected by the usual tools used to measure violence. As a result, the statistics often underestimate the real incidence of the violence. This underlines the need for classification and coding systems that will provide a better understanding of the scale of the problem. This would help raise awareness of the problem and lead to the development of initiatives to deal with these cases. It would also make research data more easily available.

The interviews carried out with disabled women who had been abused by their partners or former partners provided some information about their experiences with the health services, while the focus groups with the healthcare staff gave an insight into the perceived barriers or obstacles within the system. This triangulation of data provided different perspectives of the same phenomenon, corrected any possible distortions or bias, and gave a balanced, representative overview of the situation. This allows us to make suggestions for improvements in healthcare services provided to disabled women in cases of IPV. The women who took part in the study had various different disabilities, which made it possible to carry out a more detailed analysis of the types of abuse associated with disability. Furthermore, the healthcare professionals who took part in the focus groups all worked in different speciality areas, providing several different viewpoints of the same problem.

With regard to the limitations of this research, given the nature and aim of this study, detail and subjective perspective are achieved at the cost of the ability to generalize the results. However, the information gathered is of great interpretative value and could be used to define new hypotheses [17].

Furthermore, although this study meets all the requirements of methodological rigor in qualitative research, in terms of both the selection criteria for the sample and the procedure for gathering and analyzing data (confirmability and transferability), there are some other ways in which study validity could have been improved. First, no profiles of young women (under 25) were obtained, and specific forms of violence may occur in this group due to the unique intersection of age and disability. However, it is important to take into account that these results are based on the experiences of women who were not in care, so it is possible that in other contexts (i.e., women in care) the experiences of violence would be different. Furthermore, the women who took part in the study were approached via associations that support disabled women. We believe that the way in which the abuse is dealt with has a number of unique characteristics, as when these women were interviewed they already had the support of a network. There is also a limitation related to the healthcare professionals interviewed, as social desirability bias may occur in focus groups in which participants try to reflect upon and evaluate their own work dynamic.

Conclusions

This study suggests that abusers use disabilities to hurt their victims, and to increase their dependence and isolation. But women with disabilities do not perceive the health system as a resource for solving the situation of abuse. Health professionals have some uncertainty when it comes to detecting and dealing with situations of violence against disabled women. Coordination and cooperation between services that care for abused women and those that care for women with disabilities is therefore essential.

The results of this study provide an overview of the problem of IPV in disabled women, but more research needs to be carried out in this field, analyzing women's experiences of violence according to the type of disability they have, and including other types of violence identified by disabled women.

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