

Preface

Gender violence in the form of intimate partner violence and sexual assault commonly occurs within every known socioeconomic, racial, cultural, and religious group. Effective intervention addressing gender violence needs not only to work with individual survivors, perpetrators, and children who have witnessed abuse but also needs to include primary prevention strategies that are centered in perspectives from within diverse populations and communities. Changes at individual, community, and societal levels need to take place. One set of institutions which could be more useful in the movement to end gender violence is religious congregations. While there are values within many diverse religious traditions and communities which could be tapped to help these groups become better allies in the prevention and treatment of gender violence, these prosocial values need to be developed beyond possibilities into behavioral realities. This volume empowers mental health professionals both to consult with religious communities in efforts to address gender violence against persons with disabilities and to be able to provide appropriate interventions for religious survivors of gender violence with disabilities on an individual level.

Women with disabilities experience gender violence more frequently than the general population. Survivors with disabilities encounter significant barriers that interfere with obtaining help or finding professionals with competency in both gender violence and disability. Religious barriers to seeking help for gender violence survivors and religious theologies that have negative consequences for persons with disabilities in religious communities have also been found. On the other hand, there are a number of positive steps on which mental health professionals and religious communities can work together to assist survivors with disabilities and their children. This book uses a transformative justice framework to explore research-based principles that empower individuals and support healing at the intersection of religion, gender violence, disabilities, and social location.

The higher gender violence prevalence rate for persons with disabilities is composed of multiple components. First, gender violence is not uncommon in the general population. There is a vulnerability to gender violence we each face, both persons with and without disabilities, even though this risk is not consciously

considered by many. This component of vulnerability to gender violence is countered by traditional models of gender violence prevention (e.g., bystander empowerment training) and treatment (e.g., cognitive processing therapy for survivors and group therapy targeting power and control in perpetrators).

A second component of the higher prevalence rate concerns enhanced vulnerability as a function of biological, physical, or other characteristics of a person with a disability which might increase the likelihood of the person encountering gender violence. This component is often the focus of medical models of disability which tend to equate disability with a physical limitation or a negative state that must be cured. Treatment modalities which address this component of vulnerability to gender violence can have some positive effects if they promote full inclusion and empowerment of persons with disabilities. Sometimes proponents of the medical model take into account complexities involving the abusive behavior of caretakers which may not be an issue in the temporarily abled bodied (TAB) population. Abusive behavior in caretakers has led many in the field to prefer the term “interpersonal violence” instead of “intimate partner violence” or even “gender violence” for violence against persons with disabilities. Unfortunately, medical models of disability also tend to be paternalistic, emphasizing dynamics of exerting protective power and control over persons with disabilities, and can inadvertently set the stage for abuse to occur. This is a major limitation which leads sensitive mental health professionals, advocates, and religious communities to use more advanced models that actively promote the full inclusion, empowerment, and dignity of persons with disabilities.

A third component of vulnerability to gender violence in persons with disabilities results from the way in which disability is socially constructed. For example, consider the case of someone who uses a wheelchair to get around. The physical limitation which led the person to use the wheelchair is not the disability. It is a physical limitation. A disability is created, however, if a religious institution does not have ramps or other accommodations which allow the person to move about freely in the synagogue, church, mosque, or other buildings. The disability is socially constructed. It is unnecessary and avoidable. Practitioners, scholars, and religious communities who use social models of disability focus attention on what people and institutions can do to empower persons with all kinds of physical and other limitations so that they can act independently and be fully integrated into society. In other words, they work to make sure that disabilities are not imposed upon persons with limitations. In religious language, stumbling blocks are not created for the blind (to use one of the multiple levels of interpretation for Leviticus 19:14).

Common misperceptions, stereotypes, and unconscious or unexamined prejudices concerning persons with disabilities can lead to the construction of systems which focus on control, protection, and isolation instead of empowerment and full integration of persons with disabilities into society. They also can lead to the construction of situations where abuse is more likely to occur. Theoretical models which stress the social aspects of disability and the integration of different levels of social systems in creating disabilities often can be used to shed light on this third

type of vulnerability. These integrated ecological models emphasize the intersection of disability with other sources of social location, such as gender, race, culture, religion, and sexual orientation, in attempting to analyze dynamics of interpersonal violence that affect persons with disabilities.

This work uses elements of a transformative justice framework to address the increased vulnerability of persons with disabilities for interpersonal violence. The transformative justice tradition recognizes that cultural changes regarding the construction of masculinity, femininity, and effects of these on common perceptions of normative sexual, gendered, and interpersonal behaviors are necessary to reduce the risk of gender violence for all persons. In contrast to attempts to address change at the individual or at the criminal justice system level alone, a transformative justice framework recognizes the need for profound changes in every institutional system within a culture, including religious institutions and communities, since gender violence is commonly found in every corner of society. Transformative justice focuses on empowering persons with disabilities to secure their safety, to become as independent and fully integrated into society as possible, and to make their own decisions about important facets of their lives, including living situations, violence prevention strategies, and treatment for interpersonal violence. Finally, transformative justice approaches examine the intersection of social location for persons with disabilities to direct political and systemic interventions which seek to alleviate problematic social issues highlighted by an integrated ecological model and in order to enhance the liberation and fullness of life choices for the survivor.

A useful metaphor for the goal of a transformative justice approach is that there should be “no wrong door” for survivors with disabilities seeking help (see the Minnesota Department of Health for information regarding their “No Wrong Door” policy which informs our model: <http://www.health.state.mn.us/injury/topic/safe-harbor/>). In other words, persons with disabilities who experience interpersonal violence should be able to contact clergy, mental health professionals, domestic violence advocates, disability specialists, teachers, or any other professionals and be treated in a way that acts to ensure safety, to accept and respect the person, to empower the person to make choices, and to connect with other appropriate sources in a network of help and support. Survivors should not have to determine which door of which professional is going to be supportive and helpful. Each segment of society needs to be transformed so that no door is the wrong door for a survivor with disabilities. No wrong door is a vision to work toward and an imperative to attain. There will be different implications for different professionals in different roles, but it is our job as professionals to be competent, accessible, respectful, and connected so that we can be effective in fulfilling our roles and in making appropriate referrals. Every institution and professional needs to play a coordinated role in the beneficent society. Unfortunately, the present reality misses the mark. Many survivors with disabilities encounter inappropriate responses from diverse professionals when seeking help.

Organization of the Book

Opportunities for religious communities and mental health practitioners to work together in a positive way in the movement to end violence against persons with disabilities are numerous. *Religion, Disability, and Interpersonal Violence* is organized into two major parts to examine how such collaborations might take place. The first part emphasizes foundational issues. Lund and Thomas (Chap. 1) provide a broad overview of disability-specific factors that impact abuse vulnerability, reporting, and help seeking. Nelson and Lund (Chap. 2) contribute an analysis of common dynamics of violence against persons with disabilities from within social and integrated ecological models.

It is difficult for religious communities to provide support and buffer against interpersonal violence for survivors with disabilities if persons with disabilities are not welcomed as valued members of religious congregations at the outset. Carter (Chap. 3) describes barriers to participation and belonging for persons with disabilities in religious communities, outlining empirically based practices that work to ensure persons with disabilities are actively welcomed and integrated into the community as beloved and empowered equals. Fitzsimons (Chap. 4) explains how faith organizations can function as agents of community change. She explores how mental health professionals can work to create an inclusive, comprehensive interpersonal violence prevention plan within organizations in general and religious communities in particular. Finally, Khemka and Hickson (Chap. 5) give an overview of how organizations can work to empower women with intellectual and developmental disabilities (IDD) to resist interpersonal violence. They review the unique patterns of abuse in women with IDD, the consequences of abuse, and the complexities of treatment and prevention at individual and systemic levels for female survivors with IDD.

The second part of the book examines the intersection of religion, disability, interpersonal violence, and social location. Given the overwhelming complexity of these issues, we organized the work so each chapter covers only a couple of corners of the intersection at any one time. This approach moved the work into the realm of the possible and provides the pieces of the jigsaw puzzle to empower mental health professionals to put together the big picture when working with diverse survivors with disabilities. Cramer, Choi, and Ross (Chap. 6) demonstrate how a cultural humility model can be used to work with survivors with disabilities from diverse racial and cultural groups. Saxton (Chap. 7) explores the complexity of various forms of abuse against men with disabilities in an array of relationships, unique life experiences of male survivors, and strategies for prevention and treatment. Challenges encountered by survivors in the Deaf community and for survivors who have acquired deafness or who are hard of hearing are explained by Crowe (Chap. 8). Practical advice on removing barriers to accessibility of services for Deaf survivors and for making treatment protocols culturally sensitive and appropriate is outlined. Nelson and Lund (Chap. 9) describe compelling challenges for survivors with disabilities due to socioeconomic status or geographical location. Difficulties in disclosing abuse, leaving abusive

relationships, and coping with violence can be complicated. Suggestions for how mental health providers can take these into account when designing culturally appropriate prevention and treatment strategies are outlined.

In Chap. 10, Brown explains how processes of othering and pathologizing seriously limit access to support, mental health care, and shelters for LGBTQ+ survivors with disabilities.¹ While there is a large body of research documenting problematic responses of clergy and religious persons to survivors of intimate partner violence, little research has investigated religious leader responses to IPV survivors with disabilities. Nelson, Wang, and Haagensohn (Chap. 11) report the results of a qualitative study on pastoral responses to women with disabilities (WWD) who are IPV survivors. The pastors in their study were not a representative sample but were chosen due to their reputation as being noteworthy for welcoming persons with disabilities. In spite of this being a highly select group, both appropriate and inappropriate responses of Christian pastors were noted. Examination of pastoral responses in light of professional and research literatures on IPV was used by Nelson et al. to suggest practical steps that pastors can be encouraged to take to support WWD who are IPV survivors. Nelson (Chap. 12) next interviews IPV survivors with disabilities to give us further perspective on the dynamics of the abuse of WWD and how they perceived diverse attempts to provide support. Finally, the concluding chapter explains the “no wrong door” model, suggesting best practices and directions for future research from a survivor-centered perspective.

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¹Please note that one should use they/them pronouns when referring to Brown in the third person. This means that instead of saying something like “Brown has important ideas to consider in her chapter,” one would say “Brown has important ideas to consider in their chapter.”



<http://www.springer.com/978-3-319-56900-0>

Religion, Disability, and Interpersonal Violence

Johnson, A.; Nelson, J.R.; Lund, E. (Eds.)

2017, XXIII, 230 p. 4 illus., Hardcover

ISBN: 978-3-319-56900-0