Sexual Assault in Canada

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Sexual Assault and Disabled Women
Ten Years after Jane Doe

Fran Odette

This section deals with institutional and community responses to women’s disclosure of sexual assault. Fran Odette writes about the specific experience of disabled women who are sexually assaulted, highlighting the additional consequences they face — such as being institutionalized — if their reports are disbelieved by police or by the courts. Disabled women’s vulnerability to assault is increased by the credibility gap they face, but Fran goes further in this chapter, identifying inadequate research and feminist services as implicated in the underdevelopment of disabled women’s equality rights in the context of sexual assault. Arguing that disability is a social category that is imposed, she argues that if disabled women are not “othered,” it will become obvious that the supports they require when they experience sexual assault are no different than what all women need.

Ten years after the Jane Doe legal victory,¹ and decades since the crime of sexual assault was reconceptualized in the Criminal Code,² the specificity of the sexual assault of disabled women remains largely unaddressed and meaningfully chronicled. The manner in which this ongoing failure plays out in feminist legal and academic research and theory, and in our communities, is the subject of this article.

In Canada, women with physical impairments and differences — similar to Aboriginal, racialized, and other women facing discrimination and oppression — experience the crime of sexual violence at rates of two to three times that of women who do not live with impairment or bodily difference.³ Disabled women experience and define sexual

¹ Jane Doe v Metropolitan Toronto (Municipality) Commissioners of Police (1998), 39 OR (3d) 487 (Ont Ct (Gen Div)).
² An Act to amend the Criminal Code in relation to sexual offences and other offences against the person and to amend certain other Acts in relation thereto or in consequence thereof, SC 1980-81-82-83, c 125; An Act to amend the Criminal Code (sexual assault), SC 1992, c 38.
³ DisAbled Women’s Network (DAWN), Women with Disabilities: Physical and Sexual Assault (Toronto 1994), online: <http://dawn.thot.net/sexual_assault.html>. See also
violence/sexual assault in a particular context, wherein we are devalued, desexualized, and discounted. The experience of disabled women who are also racialized, Aboriginal, poor, or otherwise further marginalized, in terms of male sexual violence is further layered by discrimination.

A prevailing mythology holds that women living with disabilities are not sexual beings and therefore are not sexually active. Rape myths tell us that disabled women are not “real targets” of sexual assault. The lived experience of disabled women who are sexually assaulted is that when such crimes are reported to authorities, our credibility is called into question, particularly those of us who live with the label of intellectual impairment, who have been psychiatrized, or who have learning differences. According to Suellen Murray and Anastasia Powell, writing for Women with Disabilities Australia:

… how “disability” and “vulnerability” are understood may be reflected in the responses of those to whom the disclosure would be made and may also result in creating barriers to disclosure. For example, a woman with disabilities may be concerned that she will not be believed because of ideas that people with disability are asexual (or promiscuous), that they lie or exaggerate, or would not be sexually assaulted (Chenoweth, 1996; Lievore, 2005; Women with Disabilities Australia, 2007b). In relation to disclosure to police by people with intellectual disabilities, Keilty & Connelly (2001) found that “two myths, in particular, emerged consistently: women with intellectual disability are promiscuous and the complainant’s story is not a credible account” (280). Police, in particular, may appear dismissive of allegations of sexual assault as the victim may be perceived as someone who could be too readily influenced and hence make a poor witness (Phillips, 1996; Victorian Law Reform Commission, 2003; Victorian Law Reform Commission, 2004).

These negative responses may be expressed as disbelief, ridicule, blame, rejection or persecution (Davidson, 1997). Due to these responses, she may be concerned that nothing will happen when she does disclose, that


something may happen that she does not want to happen, or indeed, that the situation is made worse or it is taken out of her hands.7

Indeed, the situation becomes much worse for disabled women when charges are unfounded by police or unproven in court. These negative consequences can, in turn, result in loss of caregivers, institutionalization, forced sterilization, unwanted pregnancy, racism, sexism, deportation, further sexual assaults, and even death. The case of a Toronto woman named Cinderella Allalouf, referred to later in this paper, is one such example of such dire consequences for the woman.

My work in this area and my passion stem from my location as a feminist, queer-identified, white woman with disabilities who uses a wheelchair. I became politicized regarding the realities facing disabled women and the critical intersections of gender, race, and socio-economic status as a result of the work of the Disabled Women’s Network [DAWN] and the mentorship of two of its founders, Pat Israel and Liz Stimpson. I first immersed myself in the work of violence against women as a result of working on the first Ontario government publication on disabled women.8 Freedom from violence and the rights to sexual expression and healthy sexuality as human rights led me to co-author the Ultimate Guide to Sex and Disability in 2003.9

The myths that continue to deny disabled women access to our own identity and sexuality inform my ongoing community-based work with Springtide Resources.10 The prevalence of these myths contributes to the rape and sexual assault of disabled women. And while there is no lack of personal narratives and statistics about our rapes/sexual assaults, there are no role models, little research, and no mainstream media representations to “talk back” to such constructions and falsehoods.

This chapter identifies and unpacks barriers — blockades, really —

8 Violence Against Women with Disabilities: A Service Needs Assessment (Toronto: Ontario Women’s Directorate, 2003). This study provides an overview of the service needs of women with disabilities in Ontario who experience violence in community settings. The directorate’s website is located online: <http://www.citizenship.gov.on.ca/owd/english/index.shtml>.
10 Springtide Resources promotes healthy and equal relationships by engaging diverse communities in educational strategies designed to prevent violence against women and their children, online: <http://www.springtideresources.org>.
that remain unaddressed in our feminisms and that confront disabled women and women with physical differences who are sexually assaulted. Ten years after Jane Doe successfully addressed sexual assault in the context of women’s equality rights, the rights of disabled women remain undeveloped and inaccessible. Decades since we first identified the paucity of research and meaningful data collection to capture the lived experiences of disabled women who are sexually assaulted, our agency continues to be ignored or infantilized. We are further disappeared within rape discourse, social services, government bureaucracies, and legal, medical, and other institutions.

In the first part of this chapter, I discuss questions of terminology and disability, for linguistic constructs in turn shape our thinking and practice around disability. In the second part, I expand upon the current understanding of disability, which is that it is socially constructed and imposed upon disabled persons. This discussion turns the third part into an overview of the specific experience of disabled women who have been sexually assaulted. Finally, in the fourth and fifth parts, I discuss two significant impediments to the promise of equality for disabled women who have been raped: the research gap, which means that we are hindered in our policy and legal responses, and the failure of feminist community-based services to respond to the lived experience of disabled women.

1. A FEW WORDS ABOUT LANGUAGE

I prefer to use the terms “disabled women” and “impairments” rather than “women with disabilities” and “disability,” in solidarity with the Disability Rights Movement’s [DRM] decision to move away from the medical model of disability towards a social model.

Canadian activists fought long and hard to say that I, for example, am “a woman with a disability.” It was critical, especially in our feminisms, to insert gender before disability. That particular naming practice was/is also often preferred by many women who acquire their disability after birth through accident or illness, versus those of us who are born with our impairments, who are in fact a tiny minority of the disability population. Placing the term “disabled” before gender acknowledges that the problem does not lie within the individual, but rather in a social environment that assumes ability. The reality is that any one of us can and will become physically or mentally disabled at any time, especially in a time where we (especially women) live longer lives, and,

increasingly, with less access to housing, money, and healthcare. And, sadly, often with an increased risk of experiencing violence.

Recently the terminology of “disAbility” has become popular, and while I recognize the intent, it can be seen or understood to prefer ability — with a capital “A.” Likewise, the terms “non-disabled” and “able bodied” assume ability or advantage over someone else. People in the deaf community do not identify as disabled — the “dis” is understood to be negative or tragic. They have named their community with pride in a shared identity. Although historically efforts have been made to eradicate deafness, Deaf activists have long held to a social model of disability that sees a world designed to provide access for all forms of communication. For instance, hearing children could go to school to learn sign language rather than forcing deaf kids to find ways to communicate in spoken word, which denies that American Sign Language is their first language as well as their cultural identity and connection to the Deaf community.

The language used to conceptualize violence against women leaves out many disabled women. Terms within the literature include “intimate partner abuse,” “wife assault,” and the antiquated “domestic” and/or “family violence.” Naming practices such as these fail to include disabled women whose experience of violence is at the hands of attendants, health-care providers, and other service providers. Language and linguistic choices then must be understood as barriers in existing discourse about disability that prevent disabled women who are sexually assaulted from realizing agency and action, especially when we speak of so-called “mental disabilities” versus, for example, “mental wellness.”

I do not intend to address what “disability” or impairment means in the lives of disabled women or women living with difference. The label in and of itself does not give us information about women’s experience, but rather evokes preconceived ideas about what that experience is. It is not my intention to add further to the marginalization of my sisters by framing our experiences within what has been called the tradi-

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12 I also use the terms “sexual assault” and “rape” interchangeably to acknowledge the outrageous labelling of those acts as non-violent. While I often use the terminology of “survivor” to describe women who have been sexually assaulted, I do so in celebration and recognize that “survivor” and “victim” are terms that are felt negatively by some women.

tional “personal tragedy theory of disability.” What is most important to remember when we speak of disabled women is that they are mothers, sisters, friends, daughters, wives, girlfriends, lovers, nieces, cousins, aunts, neighbours, and co-workers. They are professional and unemployed workers: some women are working, while others cannot find employment. Some women live with observable characteristics and many have disabilities that are invisible. What is important and should be at the forefront always is that we are women.

2. THE SOCIAL MODEL OF DISABILITY
I propose that “disability” be viewed through the social model, which frames an understanding of disability as reflective of barriers, prejudices, and exclusion within society, whether intentional or not, as the determining factors that define who is and who is not “disabled” in a particular cultural context.

Originating in the UK during the 1970s and continuing to develop, this politic frames disablement as stemming from environmental and structural barriers in society rather than from a person’s characteristics or physical attributes. Michael Oliver and others have written regarding this framework of the experience of disability/impairment. Social theories of disability turn the traditional medical and conceptual models inside out. No longer is a disability the disadvantage caused by a medical impairment, such as blindness or deafness. Instead, disability is disadvantage caused by the way society is organized, the way the environment is built, and the attitudes of others. The blame has been shifted away from disabled people and their impairments and onto society. If, for example, my impairment is my lack of sight, I am disabled by a society that is structured in such a way that I cannot read most written materials, know what bus is coming, or read the contents of a food package. I am disabled by a society that patronizes me, pats me on the head, and thinks “oh dear how brave” when I walk past. I am disabled by a society that believes that I should go to a special school, not have sex, and certainly not have another baby who might be blind or who might suffer because of my “disabled” parenting skills.

16 Oliver, supra note 14.
And, if I am sexually assaulted, the crime is “worse,” seen as more violent, or more contemptible, because of my disability. Or it is my fault because I am seen to have no sexuality and will not “mind” the intrusion, or will be grateful for the “interest.” Or, I will be blamed for taking my disabled sexuality out in public where it is fair game for rapists/sexual predators.

According to the Social Model of Disability Text:

The social model of disability is not a traditional diagrammatic model like many psychological and sociological models, but a progressive political concept that opposes the medical model commonly used in the health professions.

The social model of disability makes an important distinction between the terms impairment and disability.

- Impairment — Lacking part or all of a limb or having a defective limb, organ or mechanism of the body (including psychological mechanisms).
- Disability — The restrictions caused by the organization of society which does not take into account individuals with physical or psychological impairments (UPAIS, 1976).
- This distinction is embedded in social constructionism (a philosophical foundation of the social model), which states that these terms differ in that impairment exists in the real physical world and disability is a social construct that exists in a realm beyond language within a complex organization of shared meanings, discourses and limitations imposed by the environment at a particular time and place. These barriers can be divided into three categories: environmental, economical and cultural (British Council of Disabled People).17

It is fair and critical to say, however, that the social model does not itself differentiate on the basis of gender, much less around sexual assault and other crimes of violence against women. Nor, with some notable exceptions, has race been explored in a feminist context.

3. WHICH WOMEN ARE EQUAL?
A critical piece within the social construct of the experience of oppression based on disability concerns itself with “equality.”18 “Social handi-

capping” means that a person’s equality rights are impinged as they are not entitled to the same rights or privileges enjoyed by non-disabled persons. Equal rights are said to provide opportunities for increased empowerment and the “ability” to make decisions and live life to the fullest. This was the basis of Jane Doe’s legal argument that sex discrimination by police in their decision not to warn her of a serial rapist deprived her of the opportunity to protect herself from him. The social model of disability acknowledges systemic practices steeped in paternalism and framed as being “in the best interests” of those they are intended to “protect.” It acknowledges systemic responses on numerous levels founded on biased perspectives of the potential and value of those of us living with some form of difference, which in this context is called “disability.”

We know that remedies offered through the criminal justice system for sexual assault survivors are not in the best interests of the women witnesses. These can result in further subjugating us to the margins of “other” and promoting exclusionary practices that fail to work with survivors with an approach based in human rights and equity. Perhaps the largest barrier for women who have been sexually assaulted is the legal institution’s perception of raped women’s (lack of) credibility. In consequence, we know that many women do not report sexual assaults.

Yet little substantial research has been undertaken to look at the experiences of disabled women in accessing the legal and justice systems. Much of what we do know is anecdotal. Many disabled women are simply not entering the legal system unless they have accessed supports first. Stereotypes held by police officers impact greatly on whether a woman’s report will move beyond the investigating officer. Stereotypes about disabled women’s “sexual promiscuity and credibility”

20 For a recent discussion of re-victimization effected by complainant testimony in sexual assault trials, see, for example, Lynn Idling, “Crossing the Line: The Case for Limiting Personal Cross-Examination by an Accused in Sexual Assault Trials” (2004) 69 Crim LQ 69.
21 It has been recently estimated that 94 percent of sexual assaults never come to the attention of Canada’s criminal justice system. See Margaret J McGregor et al., “Why don’t more women report sexual assault to the police?” (2000) 5 CMAJ 162. See also Ontario Women’s Justice Network, online: <http://www.owjn.org/>.
skew the lens through which individual officers work with women survivors living with disability.\footnote{Ibid at 280.} Interestingly, in a study conducted by Angela Nannini in 2006, “Women with disabilities tend to disclose to the police or solely the rape crisis centers more often than women without disabilities.”\footnote{Angela Nannini, “Sexual Assault Patterns Among Women with and without Disabilities Seeking Survivor Services” (2006) 16 Women’s Health Issues 375.} In the cases of women with cognitive impairments, women’s advocates are often the ones who make the report.\footnote{Ibid.}

Further research in this area is required in order to assess the sample size within which Nannini worked and to uncover the underpinnings of how and why disabled women report sexual assault.

Like other women, if a disabled woman has a report that is acted upon by the police and she then enters the justice system, aspects of her life are put on display as she becomes the focus of the investigation instead of the accused.\footnote{Benedet & Grant, supra note 19 at 518.} We also know that the law does not address the similarities of women’s experiences by acknowledging existing research and statistics on the high rates at which disabled women are sexually assaulted, nor does it seek meaningful resolutions to the crime outside of a law and order context. As a result, disabled women seeking justice for male violence are subject to having the quality of their resistance to unwanted sexual advances brought into question, to having their previous sexual experiences used inappropriately to interpret the particular sexual encounter at issue, and to having superficial reference made to sexual autonomy at the expense of the protection of bodily and psychological integrity from exploitation by men in positions of power over them.\footnote{Ibid.}

Janine Benedet and Isabel Grant have produced an important piece of research that examines the complexities in criminal trial proceedings involving women with cognitive impairments who experience sexual assault. In particular, women with cognitive impairments are viewed as lacking credibility and making poor witnesses because of weaknesses in their narratives, recall, and “suggestibility.” Furthermore, disabled women’s sexual histories, not unlike non-labelled women’s sexual his-
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tories, become fodder for the defence and even for the Crown,\textsuperscript{28} who, in many cases, is also informed by the pervasive mythologies around disabled women’s sexuality. In many criminal trials involving women with disabilities as complainants, another binary is imposed: disabled women are either seen as eternal children needing to be protected, or as adult women whose sexuality and behaviour is “deviant” as a result of their disability.

Take the case of Cinderella Allalouf, a Toronto woman who emigrated from Jamaica in 1975 and experienced her first hospitalization for symptoms of schizophrenia shortly thereafter. According to a \textit{National Post} newspaper article, the circumstances of her life and death went like this:

Ms Allalouf was a profoundly schizophrenic 39-year-old woman with a long criminal history who had been found unfit to stand trial on charges of child abduction, and placed in custody at the Queen Street Mental Health Centre, in the new medium-security forensics ward run by Mr Malcolmson. She was the only woman among 19 mentally ill male inmates, all there on orders of a criminal court. She became pregnant within a few months of her committal in May 1996.

Her family refused a hospital recommendation of abortion, and she delivered a boy at Mount Sinai Hospital in April 1997. Eight hours later, having received only minimal amounts of pain drugs, she died in a recovery room of a “sudden cardio respiratory arrest.” A 1999 coroners’ jury would later rule it “a sudden unexpected maternal death following Cesarean section, associated with schizophrenia” by “undetermined” means.

In the malpractice action brought by Ms Allalouf’s sister Miriam Eccleston, Mr Malcolmson is named as a defendant along with the province, the Queen Street Mental Health Centre, the Metropolitan Toronto Forensic Service and other medical staff. The claim is that they were negligent in failing to protect Ms Allalouf from harm while she was a patient. The defendants contest the allegations, which have not been tested in court.

According to a 2000 report by Ontario coroner Dr William J Lucas, Ms Allalouf was “sexually aggressive, inappropriate, intrusive, difficult to redirect. Many of her co-patients found her behaviour distracting, unsettling and even repulsive.” She was frequently placed in locked seclusion, for up to eight days at a time.

\textsuperscript{28} \textit{Ibid.}
A source close to the trial said the parentage of the child is not established. He is now 12 years old, [lives with disabilities] and being raised by his aunt, Ms Eccleston.29

Not reported or remarked upon is the fact that Miriam Eccleston reported the rape of Cinderella during her forced confinement at Queen Street — which resulted in her pregnancy — to Toronto police. The charge was not taken seriously and was unfounded due to the circumstances of Cinderella’s life.30 Her crimes, however, appear well chronicled and set the stage for her “deviant”/“disabled” sexuality. We do not read that her agency and autonomy were stripped away, that she was incapable of consenting to sex, or that choices about her reproductive rights were made for her. We are not informed that Mr (formerly Dr) Malcomson was convicted of sexual assault as a result of his relationship with another patient. Likewise, the social and economic impacts of Cinderella Allalouf’s race, economic, and immigrant status are unchronicled in the mediated narrative of her life and death.31

4. WHAT’S A FEMINIST RESEARCHER TO DO?
It was only in 1985 that the Canadian Charter of Rights and Freedoms prohibited discrimination based on disability and in 1986 that the Supreme Court of Canada ruled that persons with mental disabilities cannot be forced to undergo sterilization for non-therapeutic reasons (Re Eve case).32 In theory, the Charter ought to ensure that social, government, and legal institutions are held accountable in order to protect the rights and freedoms of citizens. In practice, however, with the exception of the result in Jane Doe, we are not examining systemic discrimination within other of our institutions that also impact on survivors of sexual violence. Such intransigence is noted globally, as explained by UNIFEM:

31 Ibid.
Fighting gender-based violence is a major concern for UNIFEM, because violence against women is a universal problem and one of the most widespread violations of human rights. One in three women will suffer some form of violence in her lifetime. Despite some progress on this issue over the past decade, its horrendous scale remains mostly unacknowledged.33

In Canada, we know that those most impacted by gender-based violence are Aboriginal women living in cities, and in rural and remote northern communities. We know that disabled women and women with physical differences are members of all of those communities. And we know that many women facing multiple and intersecting forms of discrimination and oppression do not benefit from the social policies designed to respond to violence and abuse.34

There is a growing body of research examining the complexities of women’s experiences in accessing services.35 Feminist researchers have challenged the way research and data collection occurred around the issue of violence against women because it was conducted in a vacuum of lived experiences and grounded in methodological approaches that were problematic.

However, with respect to women’s experience of sexual violence and disability/impairment, there remain problem areas in our research and theory. They include:

1. A singular focus on specific forms of violence, ie sexual violence, over other forms of violence.
2. A focus on specific “perpetrators,” such as intimate partners, to the exclusion of others, such as caregivers (formal and informal). Many disabled women are not in intimate relationships and therefore their experience of sexual assault by those who are not partners is significantly under-explored in the research.36
3. The use of “convenience samples,” rather than including questions within representative samples where women can self-identify as living with disability or difference, has limited our

35 See, for example, Patricia Stevens, “Marginalized Women’s Access to Health Care: A Feminist Narrative Analysis” (1992) 16:2 Advances in Nursing Science 39.
36 Nannini, supra note 24 at 377.
knowledge base. As a result, we are only reaching women who come forward versus those in institutional settings and those who are highly isolated because of family and geography, and who do not see their experience as violence that can be reported, but rather as a reality of their lives.

4. The use of narrow definitions of disability that result in the exclusion of some women who live with impairments. The hierarchy of disability experience is replicated in many of these studies depending on how one responds to the questions asked, who is doing the research, and their research objectives.

The first significant contribution on violence against disabled women came from DAWN, which placed the issues of violence against disabled women at the forefront of government and community discussions. In addition, there has been feminist research out of the US and Australia. A noteworthy contribution has been delivered by Dick Sobsey, whose work regarding violence against disabled persons is widely referenced. It lacks, however, a solid, gendered, anti-racist, anti-oppression analysis. While the most recent research on issues related to woman abuse and disability by Douglas Brownridge is more inclusive, the gap in feminist-based research and writing remains.

5. BARRIERS ON OUR FRONT LINES
To recap: we know that disabled women are at a much greater risk of sexual assault than their non-disabled counterparts, and that male violence can be the cause of disability. We are also more at risk for multiple acts of violence by more than one perpetrator, and experience forms of violence that are particular to living with disability, ie invol-

39 Chenoweth, supra note 5.
42 Holly Ramsey-Klawinski, Widening The Circle: Sexual Assault/Abuse and People with Disabilities and the Elderly (Madison, WI: Coalition Against Sexual Assault, 1998).
untary sterilization, termination of pregnancy, or forced pregnancy. In his comparative study of women living with and without impairment, Douglas Brownridge documents a growing gap between these two groups of women in their vulnerability to violence: in 1993, 19% of women with disabilities experienced violence, rising to 39% in 1999, and to 85% in 2004.\footnote{Brownridge, supra note 42 at 252.} Having studied 6,769 women in the 2004 survey, he reports that disabled women experience sexual assault at three times the rate of non-disabled women.\footnote{Ibid at 240.}

Furthermore, we know that disabled women living with disabilities, including women who are from the Deaf community, have many social locations other than disability or difference.\footnote{Keran Howe, “Human Rights of Women with Disabilities” paper presented to 16 Days of Activism Against Violence Against Women Forum (Melbourne, Australia), Women With Disabilities Australia, Conference Papers, Articles and Reports, 2001–2005, online: <http://www.wwda.org.au/confpaps2001.htm>. See also, online: <http://www.wwda.org.au/confpaps2001.htm>.
} Much of the research tends to identify our experience of disablement or impairment as homogenous, and to collapse our experience of trauma after violence. Nannini suggests that “assault and post assault survivor responses, may influence survivor outcomes.”\footnote{Nannini, supra note 24 at 375.} However, few studies have looked at those issues comparatively, and most have focused on one disability experience.\footnote{See, for instance, Dicky Sobsey & Tanis Doe, “Patterns of Sexual Abuse and Assault” (1991) 9 J Sexuality & Disability 243. See also Young, supra note 39.
}

Research that does not examine the complexities and breadth of lived experience, related to trauma and disability, plays into the victimology constructs that even we, as feminists, ascribe to disabled women.\footnote{Jane Doe and others address similar attitudes that position raped women only as victims and deny them sexuality, agency, and choice: Jane Doe, The Story of Jane Doe (Toronto: Random House, 2003).} Who tells/mediates our stories is also determined by the nature of our disability. Nannini speaks to women with intellectual disabilities who seek support; she argues that we must differentiate between support and “taking over” or “helping.” Someone without language, for instance, can trigger our discomfort, pity, and fear and cause us to make arrangements or suggestions that are not in her best interest, but instead assuage our feelings. She states that the stories of “survivors with cognitive disabilities […] were more often told through another per-
son."49 Without more research into women’s narratives, she suggests that it is possible to attribute the “patterns of disclosure for women with cognitive disabilities [as] influenced by these confidants.”50

When looking at the hierarchy of disablement and who is credible as the “story-teller,” compare a speaking, white woman in a wheelchair who is employed to a young, racialized woman who lives with a cognitive and a communication impairment and who uses a word board. Prejudice, fear, and stigma (conscious or not) associated with each of those locations affects providers’ responses to disabled survivors as credible witnesses or victims. Disabled women speak about their experiences with service providers and support workers (feminist and not), who do not “see” her or believe her, which in turn affects her ability to see herself as entitled to services from providers.

Rape mythology lives on, rages on, against women living with and without impairment or difference. Survivors of sexual violence who are not believed or are not seen as “credible” undergo significant levels of isolation, self-doubt, and reluctance to report or seek supports.51 Providers who fail to recognize that many women who are seeking services, including legal remedies, have a previous history of being undermined and having their potential underestimated, do them a grave disservice. As a result of the limited skills of individual workers and agencies, additional barriers have been created for disabled women.52

Few VAW agencies are able to engage in meaningful ways around issues of disability and difference without framing those issues as: “We don’t have enough money to build a ramp,” or “We’ve ended up using that accessible room as an office because we don’t have enough space, and we can’t really ‘hold’ that room should someone come in that needs it,” and so on. I see the rationale behind these statements as simplistic and reflective of a lack of commitment and will on the part of those service providers to engage authentically with the issues around women and disabilities. Many women have been “severed from the sister-

49 Nannini, supra note 24 at 378.
50 Ibid at 378.
hood" because the characteristics of their impairments make others uncomfortable. Their lives and experiences and ways of being in the world counter the images still strongly held by many because they challenge what it means to live in bodies that are impaired, to have ways of learning that are different, and to experience the world through the long-standing effects of discrimination, poverty, and isolation. Thus, disabled women’s “impairments run counter to the images of women that feminists promote: strong, smart and powerful.” Before we can stop feeling fearful, superior, and uncomfortable, we need to engage in meaningful dialogue — as disabled advocates, as activists, and as academics/researchers who do not live with impairments. Finding excuses as to why it is not possible to be inclusive is just that — an excuse.

At Springtide Resources, while we do not provide direct service such as counselling or legal advice, we often receive calls from VAW agencies saying: “We have a woman here at our facility, and we’re not sure what supports we can get for her.” After responding, I am left to wonder: “Why do supports for disabled women look radically different than they do for a woman who doesn’t currently live with impairment?” How is it that we still continue to “other” women’s experiences because of the distancing that occurs when disability or impairment enters the room? How do we apply the social model of disability to and within our feminisms? I wish I could say with confidence that we no longer tolerate indifference, subtle forms of racism, or other forms of oppression against women when they access women’s services. While it is true that within the VAW sector we are less likely to tolerate workers’ hesitations to engage with women whose race, sexualities, gender identities, or heritage is not the same as their own, we still are not where we should be.

The task before us of eliminating sexual and physical violence against women requires us to create proactive measures and processes in which women are at the core, and to challenge existing myths and stereotypes entrenched in beliefs about all women’s deficits and lack of capacity. We know that there are significant gaps in the way that services address intersecting forms of oppression and the impact on violence survivors. We need to be prepared to challenge the work around what constitutes “best practices” and to focus instead on learning from women with whom we engage directly as to what does and does not

work for them, and then we need to develop new practices. We must acknowledge that in order to move forward in the work, we need to think differently about the work and who it includes. To eliminate all forms of violence against women, we must live up to inherent values that push back against the beliefs that support and promote the privileges of some women over the rights of others. For some of us, this might be the first time we have been “given permission” to make our own decisions. However, for many of us, our lives are considered to be on the fringe of what is known about women’s lives and the experience of trauma and violence.

We must ensure that disabled women and our allies ensure that the work we are doing to eliminate sexual violence is inclusive and reflective of the lives of women and children whose voices/perspectives have not been heard. As feminists living with and without impairments, we need to recognize the strength and resilience of women to do the work necessary to change institutional practices and policies that fail to include disabled women as full human beings. We must come out of the silos we have developed in our VAW communities, which replicate the institutional structures we rage against. Above all, we must not make this work the responsibility of disabled women alone.