HHS Public Access

Author manuscript

*Ann Epidemiol*. Author manuscript; available in PMC 2016 June 01.

Published in final edited form as:

*Ann Epidemiol*. 2015 June ; 25(6): 455–457. doi:10.1016/j.annepidem.2015.03.017.

# The association between disability and intimate partner violence in the United States

**Matthew J. Breiding, PhD**[a,*] and **Brian S. Armour, PhD**[b]

[a]Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, GA

[b]Division of Human Development and Disability, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention, Atlanta, GA

## Abstract

**Purpose—**Prior research has shown that people with disabilities are at greater risk of intimate partner violence (IPV) victimization. This study seeks to examine the link between disability and IPV in a nationally representative sample of U.S. women and men. Also, by establishing that disability preceded recent IPV victimization, this study allows for a more thorough understanding of whether people with disabilities are at greater risk of victimization subsequent to having a disability.

**Methods—**Data were analyzed from the 2010 National Intimate Partner and Sexual Violence Survey, an ongoing, national random digit dial telephone survey of U.S. adults. Estimates of age-adjusted 12-month IPV prevalence by disability status were calculated.

**Results—**Compared to women without a disability, women with a disability were significantly more likely to report experiencing each form of IPV measured, which includes rape, sexual violence other than rape, physical violence, stalking, psychological aggression, and control of reproductive or sexual health. For men, significant associations were found with respect to stalking and psychological aggression by an intimate partner.

**Conclusions—**The results suggest that people with a disability are at greater risk of victimization and that primary and secondary prevention efforts might be targeted to those with a disability.

### Keywords

Intimate partner violence; Domestic violence; Sexual violence; Disability

[*]Corresponding author. Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Highway, NE, Mailstop F-64, Atlanta, GA 30341-3717. Tel.: +1-770-488-1396; fax: +1-770-488-4349. dvi8@cdc.gov (M.J. Breiding).

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease and Prevention.

## Introduction

Intimate partner violence (IPV) is a public health problem that annually affects at least 12.5 million women and men in the United States [1]. Beyond the immediate risk of physical injury and death, IPV has been associated with a range of long-term physical and mental health problems [1]. Disability affects more than 56 million Americans [2] and has been previously associated with a greater risk of violence victimization in general [3–5]. Disability has also been associated with IPV victimization in particular, with people who are disabled at nearly double the lifetime risk of IPV victimization [6]. The *World Report on Disability* identified violence victimization as one of the key threats to health among people with disabilities [7]. People with a disability may be particularly vulnerable to IPV victimization for a number of reasons, including potential physical dependence on an intimate partner, as well as higher levels of poverty, social isolation, and perceived vulnerability by perpetrators [8].

A review article identified that a critical gap in the literature is a lack of studies addressing the temporal relationship between disability and IPV [3]. Consequently, an unanswered question is whether disability typically precedes IPV victimization or follows IPV victimization [3]. The present study seeks to address this gap by examining the temporal precedence of disability relative to recent IPV victimization, allowing for a more thorough understanding of the risk for IPV victimization subsequent to having a disability.

## Methods

The present study used data from the National Intimate Partner and Sexual Violence Survey (NISVS). NISVS is an ongoing, national random digit dial telephone survey of the noninstitutionalized English- or Spanish-speaking U.S. population aged 18 years or older. NISVS assesses a broad range of experiences related to sexual violence, stalking, and IPV [9]. A total of 9086 females and 7421 males completed the survey in 2010. Approximately 45.2% of interviews were conducted by landline telephone and 54.8% of interviews were conducted using a respondent's cell phone. The overall weighted response rate of the 2010 survey was 33.6% [10]. The weighted cooperation rate was 81.3% and reflects the high proportion of respondents who agreed to participate among those who were contacted and determined to be eligible. After a single adult respondent in a household was randomly selected to participate, the interviewer administered an informed consent procedure that provided information on the voluntary and confidential nature of the survey as well as the potential benefits and risks of participation. The survey protocol received approval from the Institutional Review Board of RTI International.

NISVS includes 60 behaviorally specific questions that assess IPV victimization as follows: rape (completed or attempted forced penetration or alcohol- or drug-facilitated penetration); sexual violence other than rape which includes being made to penetrate someone, sexual coercion (nonphysically pressured unwanted penetration), unwanted sexual contact (e.g., kissing or fondling), and noncontact unwanted sexual experiences (e.g., being flashed or forced to view sexually explicit media); physical violence (e.g., kicked, slammed against something); stalking (e.g., receiving unwanted e-mails, instant messages, messages through

social media; having someone approach or show up in the victim's home, workplace, or school when it was unwanted); psychological aggression (e.g., called names, threats to harm victim or loved ones); and control of reproductive or sexual health (refusal to use a condom; attempts to get a partner pregnant against a partner's wishes). Questions were asked in relation to violence experienced over the lifetime, but only the questions inquiring about IPV experienced within the 12 months before the interview were examined in this study. Respondents were told that intimate partners included "spouses, boyfriends, girlfriends, people you have dated, people you were seeing, or people you hooked up with". A complete list of the violence victimization questions measured in NISVS has been published elsewhere [9].

Consistent with the two standard disability identifiers from *Healthy People 2010* objective DSC-1 [11], respondents were identified as having a disability if they answered "yes" to either of the following questions: "Are you limited in any way in any activities because of physical, mental or emotional problems?" and "Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?" Respondents who answered "no" to both questions were identified as not having a disability. Respondents providing affirmative responses were asked "How long have you been limited in this way?" and/or "How long have you been using this equipment?" Response options were "less than one year," "more than 1 year but less than 3 years" or "3 or more years." Respondents were classified as having an existing disability (at 12 months prior to the survey) if they reported that the duration of their disability was more than 1 year in duration.

SAS-callable SUDAAN, version 11.0 (Research Triangle Institute, Research Triangle Park, NC) was used to account for the complex survey design. Age-adjusted prevalence estimates and corresponding 95% confidence intervals (CIs), stratified by gender and disability, were produced for the following six forms of IPV: rape, sexual violence other than rape, physical violence, stalking, psychological aggression, and control of reproductive or sexual health. Estimates were age-adjusted to the 2010 U.S. standard population [12]. Logistic regression models were estimated to examine the association between disability and each form of IPV, controlling for age (years), family income (dollars), race or ethnicity (Hispanic; black, non-Hispanic; white, non-Hispanic; Asian or Pacific Islander; American Indian or Alaska Native; and Multiracial), and education (did not graduate high school; high school graduate; some college; and college graduate).

## Results

Nationally, the prevalence of having a disability was 23.8% among women and 20.1% among men. The 12-month prevalence estimates of the various forms of IPV for women were as follows: rape, 0.6%; sexual violence other than rape, 2.3%; physical violence, 4.0%; stalking, 2.8%; and psychological aggression, 13.9%. For men, the 12-month prevalence estimates of the various forms of IPV were as follows: sexual violence other than rape, 2.5%; physical violence, 4.7%; stalking, 0.5%; and psychological aggression, 18.1%. Too few men reported rape by an intimate partner in the 12 months before taking the survey to produce a reliable estimate.

The mean age of people with and without disabilities was 53.1 years (95% CI = 52.2–54.0 years) and 43.7 years (95% CI = 43.2–44.1 years), respectively, a statistically significant difference ($P < .05$). The mean age of adults experiencing any form of IPV in the 12 months before the survey was 38.0 years (95% CI = 37.3–38.8 years) compared with 47.4 years (95% CI = 47.0–47.9 years) for those who did not, a statistically significant difference ($P < .05$).

Table 1 displays the age-adjusted 12-month prevalence of each individual form of IPV for men and women, by sex and disability status. Compared to women without a disability, women with a disability were significantly more likely to report experiencing rape, sexual violence other than rape, physical violence, stalking, psychological aggression and control of reproductive or sexual health by an intimate partner, after controlling for age, family income, race or ethnicity, and education (Table 2). For men, significant associations were found with respect to stalking and psychological aggression by an intimate partner, after controlling for age, family income, race or ethnicity, and education (Table 2).

## Discussion

Our findings show that having a disability may place women with a disability at greater risk for all six measured forms of IPV. Among men, having a disability was associated with a greater risk for experiencing stalking and psychological aggression by an intimate partner. These findings differ from a prior nationally representative study that found a higher 5-year prevalence of IPV victimization among Canadian women with disabilities, compared with women without disabilities, but did not find a similar relationship relative to 12-month prevalence of IPV [13]. The reasons for this difference are unknown but could potentially be due to not having age-adjusted prevalence estimates.

The results indicate a greater vulnerability to IPV victimization among those with a disability, suggesting that primary and secondary IPV prevention efforts might be targeted toward those who have a disability. In addition, prevention efforts should be attuned to the unique needs of those who have a disability. For instance, those who have a disability may be dependent on an intimate partner, particularly when the intimate partner provides care. Also, those who have a disability and wish to leave a violent relationship may have greater difficulty leaving that relationship because of an increased likelihood of financial and physical dependence on an intimate partner. Addressing these needs may be critical in assisting a person with a disability to leave a violent relationship. In addition, efforts to enhance the independence of all people with a disability could be both a key primary and secondary prevention strategy.

Early recognition and professional intervention can help reduce ongoing IPV. However, one study found that only 15% of women with a disability had ever had a medical professional inquire about potential IPV victimization [14]. The heightened risk of IPV among people with a disability suggests that medical professionals might consider regularly screening for IPV victimization among patients with a disability. However, screening patients with disabilities for IPV might be difficult if, for example, there is a dependence on an intimate partner for transportation, communication, or assistance transferring to an examination table.

Consequently, health care providers might make a concerted effort to conduct screening for IPV in private. Also, medical professionals need to consider that the primary disabling condition (e.g., intellectual difficulty) might hinder patient-provider communication; thus, health care providers may need to use alternative communication formats (e.g., written notes, sign language).

However, screening alone is likely insufficient to significantly reduce the risk of subsequent victimization. Previous studies suggest that physically accompanying a patient in contacting an appropriate referral for services, or providing a safe space for the patient to contact needed services, is associated with a reduction in pregnancy coercion and a greater likelihood of ending a relationship that was unsafe [15]. In addition, before recommending a domestic violence shelter, the provider should consider whether the facility is accessible both in terms of physical access and the caregiving needs of those with disabilities [16].

The study is subject to at least five limitations. First, NISVS data are limited to the noninstitutionalized population and likely exclude people with disabilities who reside in nursing homes and other group settings. Second, the data likely underestimated the differences between people with disabilities and people without disabilities because the study did not specifically ask about types of IPV that are unique to those who have a disability (e.g., intentional overdosing or withholding medicine, denial of food or water, restricting access to medical treatment or assistive devices, use of confinement or restraint) [3]. Third, although the overall response rate was relatively low, the cooperation rate was high. In addition, a number of efforts were made to mitigate the potential effects of the response rate, including the inclusion of a cell phone sample and the inclusion of a nonresponse follow-up protocol in which randomly selected non-responders were contacted and offered an increased incentive for participation. Fourth, it is unclear whether collection of data through a telephone survey introduced bias into the results. For example, persons with severe disabilities, or those with hearing difficulties, may be less likely to participate in a telephone survey, and they may be more or less likely to experience IPV. Finally, given that the study assessed disability defined functionally, IPV risk by disability type (e.g., mental, sensory, physical) could not be ascertained. Examining IPV victimization by disability type is a potential direction for future research.

## References

1. Black MC. Intimate partner violence and adverse health consequences: Implications for clinicians. Am J Lifestyle Med. 2011; 5:428–39.
2. Brault, MW. Current population reports. Washington, DC: US Census Bureau; 2012. Americans with disabilities: 2010; p. 70-131.
3. Hughes K, Bellis MA, Jones L, Wood S, Bates G, Eckley L, et al. Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. Lancet. 2013; 379:1621–9. [PubMed: 22377290]
4. Plummer S, Findley PA. Women with disabilities' experience with physical and sexual abuse: review of the literature and implications for the field. Trauma Violence Abuse. 2012; 13:15–29. [PubMed: 22070987]
5. Khalifeh H, Howard LM, Osborn D, Moran P, Johnson S. Violence against people with disability in England and Wales: findings from a national cross-sectional survey. PLoS One. 2013; 8:e55952. [PubMed: 23437079]

6. Smith DL. Disability, gender and intimate partner violence: relationships from the behavioral risk factor surveillance system. Sex Disabil. 2008; 26:15–28.
7. World Health Organization and the World Bank. World report on disability. Geneva: World Health Organization; 2011. Available at: www.who.int. Accessed January 7, 2014
8. Hassouneh-Phillips D, Curry MA. Abuse of women with disabilities: state of the science. Rehabil Couns Bull. 2002; 45:96–104.
9. Black, MC.; Basile, KC.; Breiding, MJ.; Smith, SG.; Walters, ML.; Merrick, MT., et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2011.
10. The American Association for Public Opinion Research. Standard definitions: final dispositions of case codes and outcome rates for surveys. 7th. Lenexa, Kansas: AAPOR; 2011.
11. U.S. Department of Health and Human Services (DHHS). Healthy people 2010: understanding and improving health. 2nd. Washington, DC: U.S. Government Printing Office; 2000.
12. United States Census Bureau. Age and sex composition in the United States. 2010. Available at: http://www.census.gov/population/age/data/2010comp.html. Accessed April 10, 2014
13. Brownridge DA. Partner violence against women with disabilities: prevalence, risk, and explanations. Violence Against Women. 2006; 12:805–22. [PubMed: 16905674]
14. Powers L, Curry MA, Oschwald M, Saxton M, Eckels K. Barriers and strategies in addressing abuse: a survey of disabled women's experiences. J Rehabil. 2002; 68(1):4–13.
15. Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. Contraception. 2011; 83:274–80. [PubMed: 21310291]
16. Healey L, Humphreys C, Howe K. Inclusive domestic violence standards: strategies to improve interventions for women with disabilities? Violence Vict. 2013; 28:50–68. [PubMed: 23520832]

## Table 1

Age-adjusted 12-month prevalence of intimate partner violence by disability status (at 12 months prior to the survey)

| Type of intimate partner violence | Women | | Men | |
|---|---|---|---|---|
| | Disability* | No disability* | Disability* | No disability* |
| | % (95% CI) | % (95% CI) | % (95% CI) | % (95% CI) |
| Rape | 1.7 (0.9–3.0) | 0.4 (0.2–0.6) | _† | _† |
| Sexual violence other than rape | 4.5 (3.2–6.3) | 1.8 (1.4–2.3) | 4.0 (2.3–6.9) | 2.1 (1.7–2.7) |
| Physical violence | 7.1 (5.3–9.5) | 3.3 (2.6–4.1) | 6.5 (4.3–9.6) | 4.3 (3.6–5.1) |
| Stalking | 6.5 (4.7–8.8) | 2.1 (1.6–2.6) | 1.3 (0.7–2.4) | 0.3 (0.1–0.5) |
| Psychological aggression | 21.0 (18.3–23.9) | 12.2 (11.1–13.4) | 25.0 (21.2–29.2) | 16.3 (15.0–17.7) |
| Control of reproductive or sexual health | 2.4 (1.5–4.0) | 1.4 (1.0–1.9) | 1.9 (1.0–3.7) | 1.5 (1.1–2.0) |

*Respondents were classified as having a disability if they reported an activity limitation or use of disability equipment and their limitation and/or use of equipment began more than 12 months before participating in the survey.

†Estimate is not reported; relative standard error more than 30% or cell size 20 or less.

**Table 2**

Association between disability status (at 12 months prior to the survey) and IPV victimization

| Type of intimate partner violence | Women | Men |
|---|---|---|
| | AOR* (95% CI) | AOR* (95% CI) |
| Rape | 4.5 (1.9–10.7)† | –‡ |
| Sexual violence other than rape | 3.0 (1.9–4.8)† | 1.7 (0.9–3.1) |
| Physical violence | 2.2 (1.5–3.3)† | 1.5 (1.0–2.3) |
| Stalking | 2.9 (1.9–4.4)† | 4.9 (2.0–11.9)† |
| Psychological aggression | 1.8 (1.5–2.3)† | 1.7 (1.4–2.2)† |
| Control of reproductive or sexual health | 2.0 (1.0–3.8)† | 1.2 (0.6–2.7) |

*Adjusted Odds Ratio, controlling for age, family income, race or ethnicity, and education.

†$P < .05$.

‡Logistic regression model did not converge due to small cell sizes.