An Analysis of Sexual Assault Support Services for Women who have a Developmental Disability

by

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Abstract

Guided by feminist social constructionism, intersectionality and the social construction of disability, this thesis investigates the ways that sexual assault support workers and disability support workers in a medium-sized Ontario city construct women survivors of sexual assault who have a developmental disability, and how their service delivery reflects these constructions. The data were collected through semi-structured interviews with sexual assault support workers and disability support workers. Results suggest that these workers construct their service users in multiple, sometimes conflicting, ways, resisting and reproducing several ableist and sexist social constructions. Furthermore, sexual assault support workers and disability support workers often construct their service users in opposing ways. This reveals a divide between the two types of organizations. Bridging this gap may have the potential to improve services for women survivors of sexual assault who have developmental disabilities.

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Chapter 1—Introduction

It is estimated that 68 to 83 percent of women who have a developmental disability[1] will experience sexual assault during their lifetime (Pease & Frantz, 1994; Tyiska, 1998). This figure is much higher than that of the general population: according to the 1993 Canadian Violence Against Women Survey, "39 per cent of women 18 years of age and older have suffered a sexual assault at least once since the age of 16" (Johnson & Dawson, 2011, p. 94). However, just like sexual assault in the broader community, the topic is often considered to be "taboo" and is rarely discussed, despite its prevalence. Even amongst feminist and disability studies scholars, the subject remains understudied.

Widely held misconceptions about sexual assault, or "rape myths," lead to the stigmatization of survivors of sexual assault (McCormick, 2010, p. 31; Redfern & Aune, 2010, p. 172). Survivors are often blamed, doubted and held responsible, which is uncommon for victims of other crimes (Canadian Resource Centre for Victims of Crime, 2009). Furthermore, hetero-normative and misogynist standards regarding gender and sexuality help to maintain rape-supportive attitudes. The effect of these attitudes is magnified for women who have a developmental disability, as they also encounter ableist stereotypes regarding sexual assault, gender and sexuality, such as the myths that all people who have a developmental disability are either asexual or hypersexual (Block, 2000, p. 245; Dotson, Stinson & Christian, 2003, p. 196; Kaufman, Silverberg & Odette, 2007, pp. 2-9), that they cannot be sexually assaulted (Kaufman et al., 2007, pp. 8-9), or that they are unreliable witnesses in criminal proceedings (Wacker, Parish & Macy, 2008, p. 89). These

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[1] When I write about "disability," I am referring to the negative effects of impairment—physical, sensory, psychological, developmental or otherwise—on a person's ability to participate in society. I discuss disability and impairment in greater detail in Chapter 3. When I use the term "developmental disability," I am referring to a lifelong disability that "significantly affects one's ability to learn and use information" (Community Living Ontario, 2010). I will elaborate upon this definition later in this chapter.

attitudes contribute to a lack of recognition that sexual assault is a problem for women who have a developmental disability (Kaufman et al., 2007, p. 9).

A number of responses to sexual assault have emerged from legal and medical professions, social work and activist communities. Of these responses, this thesis addresses the medical model and the feminist support work model. Within the medical model, doctors, including psychologists and psychiatrists, are positioned as the only people to be trusted regarding bodies and health, and medical science is considered to be objective and truthful (Lorentzen, 2008, p. 53; Todd, 1989, p. 12). In the process of medicalization, bodies, behaviours and conditions are defined either as healthy or as sick and requiring treatment (Lorentzen, 2008, p. 52; Riessman, 1983, pp. 47-48). The body of the healthy, non-disabled male is normalized and other bodies, particularly women's bodies and disabled bodies, are constructed as "inherently pathological" (Lorentzen, 2008, p. 51). The medical model has been critiqued by patients and patient advocates for disregarding patients' lived experiences and being impersonal and insensitive (Artman & Daniels, 2010, p. 443; Hendrickson, 2009; Lorentzen, 2008, p. 58; Lunsky et al., 2009; Todd, 1989, p. 13). As such, sexual assault survivors are often re-victimized within this model (Campbell, 2008; Greeson & Campbell, 2011). The feminist support work model is an alternative to the medical model that aims to reduce the risk of re-victimization by believing, empowering and supporting survivors without question (Johnson & Dawson, 2011, p. 119). Feminist support workers resist the medicalization of women's responses to sexual assault, categorizing responses to trauma as "normal" rather than disordered, as the medical model would (Ontario Coalition of Rape Crisis Centres, 2015). As opposed to the hierarchical nature of the medical model, feminist support work organizations often operate as collectives, rely heavily on volunteers, and usually offer peer support instead of formal counselling, though increasing pressure from funders to professionalize has led to changes within some of these organizations (Beres, Crow & Gotell, 2009; Campbell & Martin, 2001; Maier, 2011a; Maier 2011b).

Due to the medicalization and pathologization of women's bodies and disabled bodies, when responding to sexual assault, psychologists and other professionals working within the medical model have traditionally been trusted to work with or "treat" women who have developmental disabilities. Practitioners who work outside of this model, such as feminist sexual assault support workers, are typically not addressed in the literature on sexual assault against women who have a developmental disability (Hingsburger, 1993; Hingsburger, 1995; Hollomotz, 2011; Mansell, Sobsey, Wilgosh & Zawallich, 1996; Schwier & Hingsburger, 2000; Shames, 2006; Sobsey, 1994). Therefore, despite the prevalence of sexual violence in the lives of women who have a developmental disability, little is known about the accessibility and availability of feminist support work services for these women.

Research Questions and Research Objective

The Ontario Coalition of Rape Crisis Centres (2014) "supports increasing the accessibility to rape crisis and sexual assault centres for Aboriginal women, women of the African Diaspora, other racialized women, women living with disabilities, women in rural/remote communities and LGBITTQQ identified women." This resource does not specify whether the OCRCC has any strategies to increase accessibility specifically for women who have a developmental disability. This thesis examines the services offered by sexual assault support workers and those who serve people who have developmental disabilities in a medium-sized city in Ontario through the following research questions:

- How do these sexual assault support workers construct women who have developmental disabilities, and how does their service delivery reflect these constructions?
- How do these organizations serving people who have developmental disabilities construct women survivors of sexual assault, and how does their service delivery reflect these constructions?

Guided by feminist social constructionism, the social construction of disability, intersectionality, and the concept of "feminist in-depth interviewing" (Hesse-Biber, 2007), I interviewed two sexual assault support workers to gain in-depth information regarding the ways that their organization constructs women who have a developmental disability. I also interviewed six members of community organizations that work with individuals who have developmental disabilities in order to examine the ways in which they construct women survivors of sexual assault. The objective of this thesis is to determine how these constructions—of women who have a developmental disability and of survivors of sexual assault—affect the framing and delivery of service by sexual assault support workers and disability support workers. The semi-structured interviews were guided by theories of feminist social constructionism and, in particular, the social construction of disability.

The results of this thesis are intended to assist those who support women survivors of sexual assault who have a developmental disability—an important endeavour, considering the prevalence of sexual assault among this population. Additionally, because feminist support work organizations usually incorporate activism into their mandate, the results of this research project will be available to raise awareness around the issue of sexual assault against women who have a developmental disability. Ideally, this research is intended to improve services, raise awareness among practitioners, include disability as an important intersection for feminist research, and contribute to theory by stimulating discussion around feminism, disability and sexual violence.

Key Definitions

The following section will define developmental disability, accessibility, and sexual assault, key terms used throughout the thesis.

Developmental Disabilities

Community Living Ontario (2010) defines a developmental disability (also known as an intellectual or cognitive disability) as:

> ...simply stated, a disability that significantly affects one's ability to learn and use information. It is a disability that is present during childhood and continues throughout one's life. A person who has an intellectual disability is capable of participating effectively in all aspects of daily life, but sometimes requires more assistance than others in learning a task, adapting to changes in tasks and routines, and addressing the many barriers to participation that result from the complexity of our society.

Additionally, this organization provides common terms of reference, stating that one should say or write "'a person who has' or 'people who have' an intellectual disability, instead of referring to a person or people as 'disabled'" (Community Living Ontario, 2010). This practice is commonly referred to as "people-first" language—prioritizing people rather than constructed categories. Additionally, the term "self-advocate" is preferred to describe people who have developmental disabilities and engage in advocacy—whether in their own lives or in the broader community. It is noted that "definitions are by nature categorizing, and...it is fundamental to the goal of inclusion that people be categorized as little as possible" (Community Living Ontario, 2010). Many disability scholars have politicized the term "disabled" and prefer its use, stating that the term "'people with disabilities' signals a mainstream approach" to disability activism; an approach that is not inherently associated with social change (Shakespeare, 2006, p. 199). Despite this argument, I feel that it is important for the purpose of this thesis to use the terminology that self-advocates have chosen, and I therefore use “people who have a developmental disability” throughout this thesis.

While many organizations have been using the term "developmental disability" for a number of years, there is currently a shift toward the term "intellectual disability," as seen above. I choose to use the former term rather than the latter for reasons articulated by Brown (2002):

> The adjective 'developmental' is just vague enough to suggest the entire range of abilities that are developed by humans, and this vagueness has been useful to us by not singling out intellectual deficits. By contrast, 'intellectual' as an adjective seems to focus our attention specifically on lower intellectual functioning as the source of the disability...The danger is that the term intellectual disability may well suggest to people in the general population an inability for intellectual activity (p. vii).

In addition, "developmental disability" instead of "intellectual disability" is less othering, stigmatizing, and victimizing in the context of academia, where intellect is privileged.

Lastly, we must remember that:

> ...both "intellectual disability" and "developmental disability" are ***terms*** to be used only when necessary to describe the work we do, and should not be used merely as ***labels.*** Self-advocates have repeatedly asked us to avoid using labels. Habit and ease of conversation often lead us to use labels when it is not necessary to do so (Community Living Ontario, 2010).

Accessibility

Ontario's Ministry of Community and Social Services defines accessibility as "giving people of all abilities opportunities to participate fully in everyday life" (Queen's Printer for Ontario, 2012a). The word is often used to refer solely to physical or architectural accessibility—for example, the use of ramps, elevators, halls and doorways wide enough for wheelchairs, scooters or walkers, doors which can be easily opened and have buttons to automatically open them, bright lighting, low counters, and more (Queen's Printer for Ontario, 2012b). However, there can also be attitudinal barriers, informational or communications barriers, technological barriers, and organizational barriers (Queen's Printer for Ontario, 2012b). Attitudinal barriers are personal and societal beliefs that discriminate against people with disabilities, whereas organizational barriers reflect an organization's discriminatory policies or practices. Informational or communications barriers can be caused by print that is too small to read, a lack of text-to-speech devices, visual cues that have no audible counterparts, as well as complex or confusing language. Lastly, when technology cannot be modified to support assistive devices, such as screen-reading software, a technological barrier occurs (Queen's Printer for Ontario, 2012b). An additional concern that the Ministry does not mention is financial accessibility, as the cost of assistive devices, products, or services may be beyond what some people are able to afford. All of the above definitions and interpretations of accessibility were considered throughout the research process.

Sexual Assault

For the purposes of this research, sexual assault is defined as any sexual contact that occurs without an individual's consent, which is consistent with the definition of sexual assault in the Criminal Code of Canada (Johnson & Dawson, 2011, p. 4).

Overview of the Thesis

In Chapter 2, I review the research literature on the construction of sexual assault in Canadian society and how stereotypes and prevalent attitudes affect women survivors, particularly those who have a developmental disability. Two distinct responses to the issue of sexual assault are detailed—the medical model's response and feminist support work primarily through sexual assault and rape crisis centres. In Chapter 3, I outline feminist social constructionism informed particularly by the social construction of disability, and intersectionality, the theoretical framework upon which the thesis is based.

In the fourth chapter, I present the qualitative methodology used in this research and the importance of interviewing to feminist researchers. Further information about the interviewees as well as the recruitment, interview, and data analysis processes are provided. I will also address potential ethical concerns and the study's limitations.

In the fifth chapter, I present the resulting themes to emerge from the interviews, separated into three broad categories: resisting and reproducing ableist constructions, responses to re-victimizing constructions, and negotiating intersectional identities. In the sixth chapter, I discuss these results in relation to the research questions and the contributions they make to the research literature in this field.

In Chapter 7, I summarize the findings of the research, identify areas for further study and discuss possibilities for the improvement of existing services.

Chapter 2—Literature Review

Under Canadian law, sexual assault is any sexual contact that occurs without an individual's consent (Johnson & Dawson, 2011, p. 4). It is a gendered act—most survivors of sexual violence are women,[1] and almost all perpetrators are male (Johnson & Dawson, 2011, pp. 9, 66-69; McCormick, 2010, p. 24). According to Statistics Canada's 1993 national survey on violence against women, which interviewed a random sample of 12,300 women, 39 percent of women 18 years of age and older have experienced a sexual assault at least once since the age of 16 (Johnson & Dawson 2011, p. 94). In 2009, 34 out of 1,000 adult Canadian women self-reported that they had been sexually assaulted within the past year, a figure which does not count those sexually assaulted by spouses (Perreault & Brennan, 2010, p. 22). Though the popular belief is that most sexual assaults are perpetrated by a stranger, it is far more common for women to be sexually assaulted by someone known to them (Allison & Wrightsman, 1993, p. 51; Filipovic, 2008, p. 21; Hingsburger, 1993, p. 34; Johnson & Dawson, 2011, pp. 97, 103-104).

Of all violent crimes, sexual assault is the most under-reported, with women consistently reporting less than 10 percent of incidents to the police since Statistics Canada began recording these figures (Johnson & Dawson, 2011, p. 93). There are a number of reasons why this is the case, including stigma, widespread disbelief of survivors, and victim blaming—none of which are common with other crimes—as well as societal attitudes toward gender and sexuality (Alsop, Fitzsimons & Lennon, 2002, p. 121; Bieneck & Krahé, 2011, p. 1794; Canadian Resource Centre for Victims of Crime, 2009; Lisak, Gardinier,

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[1] Due to the fact that the majority of sexual assault survivors are women, I use female pronouns to refer to survivors throughout this thesis. However, it is important to acknowledge that others are also vulnerable to sexual assault, particularly gay, bisexual, transgender, queer and intersex people and men who have developmental disabilities.

Nicksa & Cote, 2010, p. 1331; Madigan & Gamble, 1991; Orchowski & Gidycz, 2012; Thapar-Björkert & Morgan, 2010). In this chapter, I discuss attitudes regarding sexual assault and sexuality, and their implications for survivors, particularly women survivors who have a developmental disability. I will also address community responses to sexual assault, exploring how the medical model and the feminist support model reflect, reproduce, and resist prominent societal beliefs.

Societal Attitudes and Beliefs Regarding Sexual Assault

Survivors of sexual assault face great stigma that is unique to their experience. "Rape myths" are beliefs that are widely held despite the fact that they are untrue, and enable this stigmatization to continue (McCormick, 2010, p. 31; Redfern & Aune, 2010, p. 172). Rape myths include the ideas that sexual assault is rare, that women are most likely to be assaulted by a stranger ("stranger rape" or "stranger danger"), that women lie about being sexually assaulted, and that women who are assaulted provoked it, deserved it, or should have prevented it by behaving differently (McCormick, 2010, p. 31). Society considers a "real" or "ideal" victim to be a woman whose experience is in line with these myths (Du Mont, Miller & Myhr, 2003, pp. 469-470). In reality, most survivors' experiences of sexual assault do not fall within these parameters. Rape myths are part of a broader phenomenon that feminist scholars and activists refer to as "rape culture," defined by Powell and Henry (2014) as: "the social, cultural and structural discourses and practices in which sexual violence is tolerated, accepted, eroticised, minimised and trivialised" (p. 2). In a rape culture, rape myths are unquestioned, perpetrators' actions are excused and sexual violence is normalized (Johnson & Dawson, 2011, p. 102; Powell & Henry, 2014, p. 2-4; Redfern & Aune, 2010, p. 172).

As a result of rape myths, rape culture, societal norms and assumptions regarding sexuality, and the stigma these attitudes support, survivors of sexual assault are often scrutinized, judged and held responsible. This leads to re-victimization, also referred to as secondary victimization (Campbell, 2008; Campbell & Raja, 1999). Re-victimization causes further trauma and discourages survivors from disclosing the assault or seeking support (Ahrens, Cabral & Abeling, 2009; Campbell, 2008; Campbell & Raja, 1999; Campbell, Wasco, Ahrens, Sefl & Barnes, 2001, pp. 1240-1241; Martin, 2005, pp. 2-3). Two common re-victimizing attitudes that stem from rape myths are disbelief and victim blaming. The impact of these beliefs on survivors will be examined below. In addition to re-victimizing attitudes, beliefs regarding gender and sexuality help maintain rape-supportive attitudes. The following will discuss how these attitudes influence the experience of sexual assault.

Disbelief

It is common for survivors of sexual assault to face disbelief after disclosing their experiences (Orchowski & Gidycz, 2012, p. 266). The belief that women lie about sexual violence is indicative of a larger societal distrust of women and of misogyny, and is far less common for victims of other, non-gendered crimes (Canadian Resource Centre for Victims of Crime, 2009). Most often disbelieved are women who do not represent the idea of the "real victim," as per societal rape myths (Du Mont et al., 2003). If a woman's experience does not fit into this limited "real victim" stereotype, the legitimacy of her story may be questioned by many, including family, friends, police, hospital staff and other first responders (Filipovic, 2008; Johnson & Dawson, 2011; Lisak et al., 2010; Maier, 2008; Martin, 2005). It is particularly likely that law enforcement and the judicial system will treat survivors as though they are fabricating the story. Johnson and Dawson (2011) note that:

"sexual assault is like no other crime in the efforts made to attack the victim's credibility and to question the truthfulness of her complaint" (p. 109). This frequently occurs even though false accusations of rape are no more common than false accusations of other crimes (Lisak et al., 2010). Survivors may also be doubted by informal supports such as friends, family or colleagues, to whom they are more likely to disclose than to professionals (Lievore, 2005; Ullman & Filipas, 2001a, p. 1029). However, it is likely that they will perceive the reactions of friends in a more favourable light than those of family or formal agencies (Lievore, 2005, p. vi).

Disbelief has many implications for a survivor's well-being. If family or friends do not believe her story, a valuable support network is lost and she could feel betrayed by those from whom she relies on for support (Ahrens et al., 2009, p. 89, 91; Lievore, 2005). If a medical professional does not believe an assault occurred, they may delay, refuse or withhold treatment or procedures (such as a "rape kit"). Not receiving these basic medical services has been associated with impeding a survivor's recovery process and with higher post-traumatic stress disorder (PTSD) levels (Campbell & Raja, 1999, p. 262; Campbell et al., 2001, p. 854). If a police officer does not believe her experience, the survivor may not have the option to pursue the case through the legal system. Furthermore, repeated questioning by police to check for consistency in a survivor's story can be both "emotionally unsettling and, given that trauma can impede concentration and memory…cognitively challenging as well" (Campbell, 2008, p. 704). Overall, negative reactions from others may lead to "poorer health outcomes" (Campbell et al., 2001, p. 1253), an increased risk of PTSD (Campbell et al., 1999; Ullman & Filipas, 2001b, p. 384; Ullman, Filipas, Townsend & Starzynski, 2007, p. 829), and an increased risk of comorbid PTSD and drinking problems

(Ullman, Filipas, Townsend & Starzynski, 2006, p. 131). Additionally, Logan, Evans, Stevenson and Jordan's (2005) study of barriers to services for survivors found that the fear of not being believed was a "major [reason] women do not seek help" after an assault (p. 600).

Victim Blaming

Attitudes that blame sexual assault survivors and exonerate the perpetrators are widespread (Du Mont et al., 2003; Filipovic, 2008; Logan et al., 2005; Madigan & Gamble, 1991; Maier, 2012; McCormick, 2010; Redfern & Aune, 2010; Thapar-Björkert & Morgan, 2010). According to Redfern & Aune (2010), it is either implied or explicitly stated that survivors are to blame for their own violation:

> ...that if only they hadn't drunk so much/walked down the street alone/flirted with that boy, or if they had worn flat shoes or trousers/carried a rape alarm, it wouldn't have happened. Well-meaning campaigns focus on warning women to protect themselves but neglect targeting potential perpetrators, as if rape was an inevitable consequence of being female (p. 81).

Rather than holding men accountable, it is far more common to place responsibility on women for preventing and avoiding sexual violence. Women are not just encouraged but expected to protect themselves against sexual assault, and are held responsible when they are attacked (Filipovic, 2008; McCormick, 2010; Thapar-Björkert & Morgan, 2010). By socializing women that it is their responsibility to avoid sexual assault, the insidious messaging of victim blaming becomes internalized. This, in turn, leads to a form of social control over women (Smart & Smart, 1978, p. 100 as cited in Thapar-Björkert & Morgan, 2010, p. 36). It serves to shame survivors, focus attention on women's behaviour instead of men's, and maintain the subordination of women, as well as to legitimize and normalize sexual assault itself (McCormick, 2010, p. 31; Thapar-Björkert & Morgan, 2010, p. 38).

Victim blaming attitudes follow the same pattern as rape myths such as the stereotype of the "real victim"—if a survivor's experience does not fit into these parameters, it is likely that they will be blamed by others for the assault (Du Mont et al., 2003; Filipovic, 2008, p. 23; McCormick, 2010, p. 31). As with disbelief, survivors who experience victim blaming are re-victimized. Victim blaming can originate from many sources, including family and friends, medical professionals, law enforcement, religious leaders, the media, and many others (Madigan & Gamble, 1991, pp. 5-7; McCormick, 2010, p. 31).

Like disbelief, victim blaming can affect a survivor in many ways. If they are treated as though they should have done something differently to prevent their assault, their experience is delegitimized and the perpetrator's actions are excused. Survivors may be treated as though they were "asking for it." Their claims of sexual assault may be dismissed by people to whom they disclose, and they may be ostracized from their communities and networks. Even if medical professionals provide prompt treatment, they may make judgmental comments (Madigan & Gamble, 1991, p. 6). Police and the courts are known to interrogate a survivor as though they are the suspect, rather than the victim (Ahrens et al., 2009, p. 89; Johnson & Dawson, 2011, p. 109; Maier, 2008, p. 788-789). A survivor's actions or conduct may be used by law enforcement and the judicial system to discredit them, in spite of law reforms, which disallow these tactics (Johnson & Dawson, 2011, p. 109; Maier, 2008, pp. 788-789). Defence counsel has led coordinated efforts to weaken and reverse feminist gains in law reform. It is argued that these law reforms, fought for by feminist organizations in order to protect survivors of sexual assault, have ultimately done little to change how survivors are treated by the criminal justice system (Johnson & Dawson, 2011, p. 108). Laws limiting access to the complainant's personal records and disallowing questioning of the complainant's sexual history have been enacted in order to prevent defence counsel from using this evidence to discredit survivors. However, judges retain the right to decide to introduce this information if it is deemed relevant to the trial, thereby seriously limiting the laws' ability to protect survivors (Johnson & Dawson, 2011, pp. 111, 113-114). Furthermore, the instances in which consent is not or cannot be obtained are listed in Section 273.1 (2) of the Canadian *Criminal Code,* yet the defence of "mistakenly believing" that consent was obtained may still be used (Johnson & Dawson, 2011, pp. 111-112). Depending on how a particular judge interprets consent, they may allow this defence despite the criteria outlined in the *Criminal Code* (Johnson & Dawson, 2011, p. 112). A double standard also exists regarding the consumption of alcohol by the survivor and/or perpetrator. If a woman consumed alcohol prior to being assaulted, she is likely to be blamed for the assault, whereas alcohol consumption is used to excuse the behaviour of male perpetrators (Bieneck & Krahé, 2011, p. 1794; Finch & Munro, 2007, p. 593; Stormo, Lang & Stritzke, 1997, pp. 299-303), again despite the criteria outlined in the *Criminal Code.* These efforts of defence counsel undermine feminist gains in law reform and perpetuate re-victimization in the criminal justice system.

Gender and Sexuality

Societal attitudes regarding gender and sexuality affect how sexual assault is experienced and perceived. Together, these myths and attitudes assist in sustaining stigma and contribute to rape-supportive beliefs. Hetero-normativity and misogyny form the basis for societal attitudes toward gender, sexuality, and sexual assault. In a hetero-normative society, heterosexuality is privileged as a “natural state” or a “moral accomplishment” (Berlant & Warner, 1998, p. 548). Different standards define the general categories of men and women, encouraging them to behave in certain ways, and influencing others to perceive them in certain ways. This, combined with andro-centric attitudes, ensures that women's sexuality is scrutinized and policed, and male entitlement to women's bodies is assumed. Furthermore, parents and educators often do not share accurate, comprehensive information about sexuality with young people (Perry, 2008, p. 198). This leaves youth to learn about sexuality by means that, most often, reproduce societal hetero-normativity and misogyny—such as their peers, the media, and easily accessible pornography. These circumstances all contribute to the ways in which men and women learn about their stereotypically distinct sexual roles.

Through media and pornography, men and boys absorb messages that their role in sexual encounters is to initiate and "pursue ever-higher levels of sexual intimacy" (Seal, O'Sullivan & Ehrhardt, 2007, p. 141-142). They are less likely to receive consistent messages about seeking consent, learning instead that women are "responsible for controlling the pace of sexual intimacy" (Seal et al., 2007, p. 141). These hetero-normative attitudes oversimplify sexual interactions and fail to acknowledge the intricacies of intimacy, to the point where men and boys report a belief that there are "quick and easy" general rules or answers regarding sex and sexuality (Perry, 2008, p. 197). Many of these "answers" come from pornography, which portrays sexuality both inaccurately and violently (Dines, 2010; Kimmel, 2008a, pp. 188, 207). Dines (2010) argues that pornography "hijacks" men's sexuality by limiting their imagination, causing feelings of inadequacy, and presenting a version of sex devoid of human connection or intimacy (pp. 68, 80, 84, 89). She writes that physically and sexually violent images in media—whether from movies, video games, pornography or other sources—influence the creation of boys' masculine and sexual identities (p. 63). These representations of violence are internalized, and continued exposure leads to desensitization even to images of brutal physical and sexual violence (Dines, 2010, pp. 63, 74). In addition, men and boys learn the idea that women have to be convinced or pressured to have sex—that “no” really means “yes”—and that the use of drugs and alcohol is a method to facilitate this (Kimmel, 2008a, pp. 219-220; Perry, 2008, p. 194). Linked to this, teenage boys learn that their sexuality is "to be characterized by action, control, and achievement" (Perry, 2008, p. 200). Their socialization "places special emphasis on boys' learning to control every possible variable surrounding sexual interactions, and thereby sends the clear message that sexuality should be expressed and enjoyed only in the context of a power dynamic" (Perry, 2008, p. 201). These ideas equate coercion with consent, contributing to rape-supportive attitudes.

Hetero-normativity and rape-supportive attitudes underpin a number of rape myths. A common hetero-normative, rape-supportive attitude is that men are inherently sexually dominant and cannot control their sexual urges, thus equating sex with gender and failing to recognize that this is a social construction (Alsop et al., 2002, p. 121; Redfern & Aune, 2010, p. 50). This is also a largely unquestioned gender role, exemplified by the phrase, "Boys will be boys"—a saying often used to dismiss or defend men's violent behaviour (Chemaly, 2013; Clune, 2014). Other hetero-normative, rape-supportive attitudes include the idea that rape is sex or an act of passion, and that men are entitled to sex in certain circumstances, such as after a date that they have paid for (Kimmel, 2008b, p. 301), within the context of an intimate relationship (Redfern & Aune, 2010, p. 50), or if they are powerful or famous (Kimmel, 2008a, p. 235). An extension of commonly held attitudes of entitlement is the idea that women have no right to decline sex; therefore, rape itself is a man's right

(Scully, 1990, as cited in Kimmel, 2008b, p. 330). Through these attitudes and widespread and unquestioned messages, it becomes a normative belief that sex is "a natural aspect of…masculinity" (Redfern & Aune, 2010, p. 50), as opposed to a natural aspect of all humanity (Kimmel, 2008a, p. 213).

Rape-supportive attitudes are closely linked to gender roles. Eichler (1980, as cited in Johnson & Dawson, 2011) states that "gender roles reflect male-dominated perceptions and understandings of appropriate behaviour for men and women, and the behaviours ascribed to males are more highly valued than those ascribed to females" (p. 17). As such, sexual assault can be considered "a logical outcome of the power differentials that result from the way males and females are socialized and, rather than being a deviant act, rape is a function of over-conforming to socially proscribed gender roles" (Russell, 1984, p. 117 as cited in Johnson & Dawson, 2011, p. 17). Sexually violent men are often conceptualized as perverts or deviants but, in actuality, they are "exceptionally committed to a set of norms about masculinity that makes every encounter with every woman potentially, even inevitably, about sexual conquest" (Kimmel, 2008b, p. 330).

Though societal convictions regarding male sexuality greatly affect the experience of and beliefs about sexual assault, ideologies addressing female sexuality are also influential. Throughout history, men have sought to control women's sexuality, and in many contexts it remains so today. The criminal law has been used to normalize specific expressions of sexuality while criminalizing others. Sexual assault perpetrated by an individual's spouse only became a crime in Canada in 1983 (Brennan & Taylor-Butts, 2008), and the attitude that sexual activity is only appropriate within the context of a committed relationship is still expressed within Canadian society (Dauda, 2010, p. 238). Young people's sexuality is legislated through age of consent laws, and certain sex acts are given separate status under this legislation, marginalizing queer youth and queer sexuality (Dauda, 2010, pp. 227-228; Wintemute, 1995, p. 165). "Homosexual behaviour" conducted in private spaces was decriminalized in Canada in 1969 (Dauda, 2010, pp. 232-233; Poulin, Gouliquer & Moore, 2009, p. 498) and, though same-sex marriage was legalized in Canada in 2005, it continues to be opposed by many (Dauda, 2010; Dauvergne & Brennan, 2011). These legal controls on sexuality influence societal attitudes—particularly those pertaining to women and people with disabilities.

Because women's sexuality is controlled by others, they are denied agency and their own expressions of healthy sexuality are demonized. Andro-centric conceptions of sexuality ensure that women's sexuality is defined in relation to that of men—this is both an act of control and a way to marginalize women (Alsop et al., 2002, p. 121). Andro-centrism reinforces a number of hetero-normative, binary-based stereotypes regarding men's and women's sexuality. Women are constructed as submissive, in opposition to men's construction as dominant (Alsop et al., 2002, p. 121). While men often learn that they should be in control of their sexual activity (Perry, 2008, pp. 200-201), women are constructed as sexually evasive and passive (Filipovic, 2008, p. 20; Redfern & Aune, 2010, p. 50). Instead of prioritizing assertiveness, women receive messages that define their sexual roles as compliant and inactive (Filipovic, 2008, pp. 18-20). Indeed, women are conceptualized "as less sexually motivated than men" (Redfern & Aune, 2010, p. 50). Ultimately, women and girls are often not taught to say yes to sexual activity—instead, they learn to approach it with fear and uncertainty (Filipovic, 2008, pp. 18-20).

Women are expected to constantly protect and guard themselves from being sexually assaulted; because this message becomes internalized, a form of power is asserted over all women (Smart & Smart, 1978, p. 100 as cited in Thapar-Björkert & Morgan, 2010, p. 36). In a society where the feminine is devalued, constructions of women's sexuality are highly negative. Consequently, sexual violence is common and even condoned (Valenti, 2008, p. 299).

There exists a paradox whereby women are highly sexualized, constructed as sexually available, and often pressured into having sex before they feel that they are ready, yet punished for expressing their sexuality (Redfern & Aune, 2010, p. 52). This virgin/whore dichotomy establishes women as inherently tempting, asserting that they "embody sex…and are therefore responsible for it (and for men's behaviour towards them)" (Redfern & Aune, 2010, p. 53). This is linked to the concept of men being unable to control their sexual desires (Redfern & Aune, 2010, p. 50). Messages that encourage women to subdue their sexuality are presented simultaneously with a hypersexualized, "empowered" female image idealized in popular culture (Dines, 2010, p. 102). Indeed, the hypersexualized image has become so ubiquitous that it has "overwhelmed and crowded out any alternative images of being female" (Dines, 2010, p. 105). The virgin/whore dichotomy represents a double standard—women's sexuality is marginalized and scrutinized while heterosexual men's sexuality is accepted and congratulated. The dichotomy ensures that women are punished whether they conform to these norms or not, through shaming and defamation but also through sexual violation (Jewkes, Sikweyiya, Morrell & Dunkle, 2010, p. 27; Valenti, 2008, p. 299).

Sexual assault has also been used specifically to punish or condemn gender or sexual expressions constructed as deviant. In South Africa and Uganda, the phenomenon of "corrective rape" is popularized—men sexually assaulting a woman who is believed to be a lesbian in order to "correct" them or make them heterosexual (Anguita, 2012; Nyanzi, 2013). This is not limited to these countries, and it occurs in the West, as well (Mosbergen, 2013; Silvera, 1991). Those who are asexual or transgender are also subjected to sexual violence because of their sexual or gender identity, as they do not conform to societal expectations and stereotypes regarding sexuality and gender presentation (Mosbergen, 2013).

Through the hetero-normative nature of the constructions described in this chapter, non-binary gender and sexual identities are actively marginalized. By constructing women's sexuality directly in relation to men's, the very existence of queer and transgender people is marginalized, leading to their oppression and vulnerability to violence. The intersection of sexual violence and sexual and gender identity will be explored further in the following chapter, where the feminist theory of intersectionality and its importance to research on sexual assault is discussed.

Ultimately, each of the stereotypes regarding women's sexuality—and how these constructions influence experiences of sexual violence—lead back to the notion "that sexuality defines how 'good' women are, and that women's moral compasses are inextricable from their bodies" (Valenti, 2008, p. 299). Perry (2008) argues that a sex-positive sex education curriculum will lead to "a culture where people experience sexuality in a state of well-being—a culture incompatible with sexual violence because of a deeply shared belief that sexuality is a precious part of everyone's humanity" (p. 198). Until this becomes a reality, societies will continue to perpetuate negative attitudes that lead to a devaluing of sexuality, particularly women's sexuality—therefore creating an environment in which sexual assault is normalized.

Sexual Violence Against Women who have a Disability

All of the attitudes, reactions and beliefs addressed above affect survivors of sexual assault, and the repercussions of these beliefs can vary greatly depending on individual circumstances. Experiences of oppression, such as gender, sexuality, race, class, religion and ability, all have a distinct influence. The following section will introduce some of the ways in which the experiences of sexuality and sexual assault differ for a woman who has a disability.

Similar to survivors who are able-bodied, disbelief, victim blaming, and societal convictions about gender and sexuality all affect women who have a disability; however, there are additional factors affecting women with disabilities that are not always acknowledged in discussions about sexual violence. While rates of sexual assault are high for women as a general group, the rates are far higher for those who have a disability. It is estimated that 68 to 83 percent of women who have a developmental disability will experience sexual assault during their lifetime (Pease & Frantz, 1994; Tyiska, 1998). Women as a general category are taught to protect themselves against sexual assault and are controlled by the internalization of this message, but this reality is more pronounced for women who have a disability—especially a developmental disability. These statistics, in and of themselves, show the importance of studying sexual violence against women who have a disability, as well as providing services for these women. Additionally, just as stereotypes about women's sexuality affect the perception and experience of sexual assault, the stereotypical ways in which women who have a disability are constructed are equally important to consider, a perspective that feminist scholarship has often omitted. This section will examine the factors that affect disabled women's experiences of sexual assault, particularly their dependence on caregivers, the influence of stereotypes regarding their sexuality, and how these constructions build upon or differ from those that affect non-disabled women.

Caregivers and Abuse

It is more common for a woman to be sexually assaulted by someone who is known to her than by a stranger (Allison & Wrightsman, 1993; Filipovic, 2008; Hingsburger, 1993; Johnson & Dawson, 2011). This is an important factor for women who have a disability, as they often depend on others for care or assistance, whether they are family members, intimate partners, or those who volunteer or are employed to assist them. By nature of their greater contact with caregivers, and because the work performed by these caregivers may often be intimate in nature, women who have a disability are at an increased risk of victimization (Kaufman, Silverberg & Odette, 2007, p. 274; Richards et al., 2009, pp. 188-189).

Caregivers have often been shown to hold and to reinforce negative attitudes toward sexuality in people who have a developmental disability (Owen, Griffiths, Feldman, Sales & Richards, 2000). Some caregivers may restrict access to educational materials that address sexuality and sexual assault, believing that these materials are inappropriate or irrelevant. Caregivers may also prevent a person who has a disability from seeking information or assistance outside of their home environment. When a woman who has a disability depends on an abusive caregiver for assistance with basic needs, they may have no way to report or obtain help for an abusive situation (Munson, 2011). Furthermore, the closeness of those who provide care can complicate the process of reporting an assault (Weinberg, 1988, p. 286). Schwier and Hingsburger (2000) point out that "many times people with disabilities have suffered abuse and have wanted to report it, but everyone they see around them is connected socially or professionally with everyone else" (p. 135). If the only people that a survivor trusts are somehow linked to their abuser, this isolation limits their ability to report the abuse.

Stereotypes Regarding the Sexuality of Women who have a Disability

Though all women are subjected to harmful stereotypes regarding their sexuality, women who have disabilities are affected by a number of additional myths. Garland-Thomson (2002) points out that disabled women are constructed "as asexual, unfit to reproduce, overly dependent, unattractive—as generally removed from the sphere of true womanhood and feminine beauty" (p. 266). Common myths surrounding sexuality and people who have disabilities are that they are asexual, undesirable, incapable of "real" sex, either sexually passive or perverted, and not in need of sex education (Dotson, Stinson & Christian, 2003, p. 196; Kaufman et al., 2007, pp. 2-9). The imposition of asexuality on people who have disabilities must be differentiated from asexuality as "a distinct, authentic sexual orientation or identity" (Gressgård, 2013, p. 180). While it is a myth that all people who have a disability are asexual, this does not mean that asexuality does not exist or that there are no asexual people who have a disability. It is important to acknowledge that people who have disabilities "experience sexual repression, possess little or no sexual autonomy, and tolerate institutional and legal restrictions on their intimate conduct" (Siebers, 2008, p. 136). Like women as a general category, the sexuality of women who have a disability is controlled—this control is maintained by constructing women who have a disability "as 'passive,' 'dependent' and 'in need of care'" (Bê, 2012, p. 365). While these attitudes negatively affect all people who have a disability, they have greater implications for women survivors of sexual assault.

The femininity of women who have a disability is often unacknowledged or denied. A survey of students at an eastern American university showed the differences in perception of women as a general category and disabled women:

> 'Woman' drew associations of worker (intelligent, leader, career); of sexuality (soft, lovable, orgasm); of mother or wife (wife, mother, mom, married, childbearer). When asked to associate to 'disabled woman,' students described her in terms of dependence and impairment (crippled, almost lifeless); of age (gray, old, white hair); of despair (someone to feel sorry for, pity, sorry, lonely, ugly). She was virtually never depicted as wife, mother, or worker by the more than one hundred students questioned (Hanna & Rogovsky, 1986 as cited in Asch & Fine, 1988, p. 15).

Whether women who have a disability seek to associate themselves with stereotypically feminine roles or traits or not, they are often not regarded as women at all. Able-bodied women have specific roles reserved for them—worker, partner, mother—but constructions of disabled women include "no adult roles" (Blackwell-Stratton, Breslin, Mayerson & Bailey, 1988, p. 307). Lehrer (2012) argues that even though the enforcement of strict gender roles has been problematized by feminist scholars and activists, stating that "there is a different kind of confusion and hurt caused by its absence, when it's clear that you're not being included because you've been disqualified. Disabled women must continually claim their gender in the face of active erasure" (p. 242).

The denial of adult roles or feminine identity for women who have a disability leads to further stereotypes regarding their sexuality. Siebers (2008) points out that "one of the chief stereotypes oppressing disabled people is the myth that they do not experience sexual feelings or that they do not have or want to have sex" (p. 138). For individuals who have a developmental disability, the misconception is that they simply have no capability for sexuality (Richards et al., 2009, pp. 185-186). Western society does not consider people who have a disability to be conventionally attractive, an attitude that can be internalized by people who have a disability (Milligan & Neufeldt, 2001, p. 98). For women, particularly, conventional attractiveness is linked to desire and to sexuality itself (Asch & Fine, 1988, p. 16). A person who is supposedly unattractive is not considered by society to be a sexual being.

People who have a disability experience the objectifying gaze of able-bodied people that identifies them as "other," serving to desexualize and dehumanize them (Clare, 2003, p. 257; Garland-Thomson, 2001, p. 19). People who have a disability must then learn to acknowledge their own humanity and sexuality, while claiming and reclaiming it in the face of its denial (Clare, 2003, p. 258). Clare (2003) writes:

> I spent so many years shutting the staring out, slamming the door. Friends would ask, 'Did you see that person gaping at you?' and I'd answer, 'What person?' It's a great survival strategy but not very selective. In truth, the door slammed hard, and I lost it all, all the appreciation, flirtation, solidarity that can be wrapped into a gaze. These days I practice gawking at the gawkers and flirting as hard as I know how. The first is an act of resistance; the second, an act of pride (pp. 258-259).

Just as Lehrer (2012) writes about the significance of claiming her gender, Clare acknowledges the pain of having his sexuality denied and demonstrates that, through resistance and pride, people who have a disability can celebrate their sexuality.

Even when the sexuality of people who have a disability has been acknowledged by able-bodied people, hetero-normativity continues to influence how their sexuality is perceived. Individuals who have a developmental disability, in particular, are generally assumed to be heterosexual, if not asexual (Richards et al., 2009, p. 195). In discussions and educational material about sexuality and people who have a disability, sexual orientation may be omitted, and homophobia is common (Dotson et al., 2003, p. 198; Goodley, 2011, p.

40; Hingsburger, 1993, pp. 73-76; McClelland et al., 2012, p. 811; Schwier and Hingsburger, 2000, pp. 122-123). People who have a developmental disability often lack knowledge on the subject of queer sexualities and may have fewer opportunities to encounter people or educational materials that validate these sexual identities (Garwood & McCabe, 2000, as cited in Richards et al., 2009, p. 196). Additionally, queer people who have a developmental disability may be discouraged from participating in consensual non-heterosexual sexual activity by homophobic family members or support staff (Thompson, 1994 as cited in Richards et al., 2009, p. 196; Clare, 2009, p. 138; McClelland et al., 2012, p. 811). This homophobia is intricately linked with the ableist denial of disabled sexuality (Clare, 2003, p. 258).

An extension of the myth of asexuality is the idea that people who have a developmental disability are in a state of “permanent childhood” and therefore asexual (Canadian Down Syndrome Society, 1996; Clare, 2009, p. 138; Dotson et al., 2003, p. 196; Richards et al., 2009, p. 185; Wilkerson, 2011, p. 204). This myth has been challenged in academic and disability activist communities and scholarship for many years, yet it is still a common misconception (Block, 2000, p. 247; Richards et al., 2009, pp. 185-186; Wacker, Parish & Macy, 2008, p. 89). As Dotson et al. (2003) argue, "these stereotypes are harmful because they lead either to the belief that a woman's sexual expression can be ignored or that it must be suppressed" (p. 196). Additionally, this myth reinforces the denial of sexuality and the belief that women who have a disability should not become mothers.

People who have a disability—but, most often, women—have been labelled as unfit to reproduce (Blackwell-Stratton et al., 1988, p. 307; Block, 2000; Dotson et al., 2003, p. 198; Garland-Thomson, 2002, p. 266; Siebers, 2008, p. 140). This is partially due to the attitude that they are asexual, but it is also influenced heavily by ableist—and, often, scientifically inaccurate—assumptions that parents who have a disability will pass the disability on to their children (Block, 2000, pp. 242-244; Richards et al., 2009, p. 191). Siebers (2008) writes that society expects people who have a disability to "not reproduce, but if they do…the results will be tainted" (p. 140). This fear led to widespread, state-sanctioned eugenics programs in countries such as Canada, the United States, the United Kingdom and Nazi Germany (Block, 2000; Hubbard, 1990, pp. 94-97; Malacrida, 2005; Ralstin-Lewis, 2005; Wahlsten, 1997). In addition to individuals who had a developmental disability, these programs targeted people with all types of disabilities for involuntary sterilization, as well as people living in poverty, indigenous women, those dealing with addiction, sex workers, and others (Hubbard, 1990, p. 95; Smith, 2005, pp. 81-83). The use of involuntary sterilization controlled the sexuality of people who have a disability, and women who have a developmental disability still experience coercion and pressure to be sterilized (Block, 2000, p. 247; Desjardins, 2012).

Another common myth affecting people who have a developmental disability, linked closely with the myth of asexuality, is that they cannot be sexually assaulted (Kaufman et al., 2007, pp. 8-9). Some believe that people who have a developmental disability will not understand that they have been assaulted—and that, therefore, it is not assault. This “may also help to justify the abuse for the perpetrator” (Kaufman et al., 2007, p. 278). On the other hand, since society constructs these individuals as asexual and not sexually attractive, there is the belief that no one would actually assault someone who has a disability (Kaufman et al., 2007, pp. 8-9).

These attitudes are linked to the larger disbelief of survivors of sexual assault described earlier in this chapter; however, they are distinct for people who have a developmental disability. Like survivors of sexual assault in general, this disbelief may come from caregivers, friends, and even medical professionals. Asch and Fine (1988) recall a situation in which medical staff failed to believe that a woman who had a disability could be sexually active: "So astonishing is it to some physicians that disabled women might be sexual that Galler (1984) reports completely unnecessary abdominal surgery for one woman because no one believed that someone with cerebral palsy could have the symptoms of venereal disease" (p. 21). If these medical professionals did not even consider that a woman with cerebral palsy could engage in consensual sexual activity, it is questionable as to whether they would believe a report of sexual assault. Furthermore, because of their perceived intellectual capabilities, the criminal justice system often considers people who have a developmental disability to be unreliable witnesses. This belief persists despite poor justification for it. As Wacker, Parish and Macy (2008) note, "cognitive impairments do not affect the type of memory necessary for providing a reliable testimony during trial" (p. 89). Additionally, courts often rely on IQ and mental age testing, despite the fact that these measures are not particularly valid for their purpose (Wacker et al., 2008, p. 89). In spite of this evidence, survivors themselves are still constructed as not credible; therefore, disbelief and re-victimization are to be expected.

Another justification for eugenics programs and societal control over the sexuality of people who have a disability lies in the myth of hypersexuality or "sexual perversion and deviance" (Richards et al., 2009, p. 185). Eugenics programs thrived because the public feared "the assumed 'obsessive sexual nature' of this group" (Block, 2000, p. 245). As with the disproved but still common myth of asexuality, the inverse myth of hypersexuality or sexual deviance persists (Block, 2000, pp. 242-244). This stereotype causes victim blaming to appear once again. Survivors are sometimes blamed for causing their assault by provoking their abuser or being "aggressive" (Block, 2000, p. 248). In an American court case, the defence argued that a woman who claimed she was assaulted actually "craved" the sexual attention (Block, 2000, p. 248; Wacker et al., 2008, p. 90). Above all, defence lawyers—among others—have argued that because of their supposed "obsessive sexual nature" (Block, 2000, p. 245), it is not the accused perpetrator who is "sexually threatening" but the survivor herself (Wacker et al., 2008, p. 90). As with able-bodied women who are subjected to victim blaming, the survivor's conduct or her "inherent" traits become the focus of the legal proceeding, rather than the alleged perpetrator's actions (Block, 2000, p. 249). For women who have a developmental disability, these attitudes link back to the mistaken belief that they cannot be sexually assaulted because of who they inherently are.

The belief that people who have a disability cannot be sexually assaulted has dire consequences. As Kaufman et al. (2007) note, “this myth sets up one of the most horrific, self-perpetuating cycles: if you are not at risk, why bother creating programs for prevention and support? This attitude places you at greater risk, and the cycle continues” (p. 9). Though some caregivers still believe that sterilization is the best way to protect a woman who has a developmental disability from sexual assault (Block, 2000, p. 247), this approach does not address the root of sexual violence, may protect from pregnancy but not assault, and can be violent in and of itself.

As this chapter has discussed, stereotypes and societal attitudes regarding the sexuality of men and women, with a disability or able-bodied, greatly affect survivors of sexual assault. They experience disbelief, victim blaming and shaming, all of which lead to stigma, low reporting rates, and impunity for perpetrators. A number of community responses have emerged to respond to survivors of sexual violence and people who have a developmental disability, but often in ways that are mutually exclusive.

Responses to Sexual Assault

Varied responses to sexual assault in Canada have stemmed from law enforcement, law reform, medical professions, social work, health education and activist communities. While each response should be considered in the broader context of sexual assault prevention and support, this research will consider formal responses to sexual assault that are meant to address survivors' health and emotional well-being. The two major responses in this field have come from the medical model and, following it, the feminist support model. This section will outline each of these models, discuss how they respond to the problem of sexual assault and to sexual assault survivors, and begin to engage with critiques of each model.

The Medical Model and the Medicalization of Marginalized Bodies

The medical model regarding women's health incorporates a pervasive belief in biomedicine and the power of doctors (or other health care professionals, including but not limited to psychologists and psychiatrists) in Western society (Todd, 1989, pp. 12-13). Doctors are held in high esteem, assumed to possess "superior knowledge [and] technical skill" (Todd, 1989, p. 12), perpetuating the notion that medical professionals are the only people to be trusted and consulted regarding a person's body and health. This model privileges objectivity and neutrality, assuming that everything about health, illness and patients has to do with biology and biomedicine. Medical science is seen to represent truth and reality, beliefs that are internalized in Western societies (Lorentzen, 2008, p. 53).

Medicalization is "a social process in which bodies and social circumstances are defined from a biomedical perspective as requiring biomedical intervention" (Lorentzen, 2008, p. 52). It is through medicalization that "certain behaviors or conditions are given medical meaning,

that is, defined in terms of health and illness" (Riessman, 1983, pp. 47-48). Medicalization and the medical model are mutually reinforcing, positioning the body as something that needs to be treated and made "normal." When partnered with the supposed superiority of medical professionals, medicalization creates a power imbalance where all people are bound to become patients and doctors have special authority that is largely unquestioned (Lorentzen, 2008, p. 53).

Medicalization particularly affects marginalized people, who are measured against the healthy, non-disabled male body as the norm. In addition, the healthy male body is more widely studied and, therefore, is better understood by medical professionals (Messing, 1995; Garland-Thomson, 2001, p. 10). Until recently, medical practice and medical research has constructed the female body as "inherently pathological" (Lorentzen, 2008, p. 51) and has neglected to study it extensively (Lorentzen, 2008, p. 51; Felstiner, 2000, pp. 207-208; Messing, 1995). As such, the medicalization of women is one component of the perpetuation of sexism in our society (Lorentzen, 2008, p. 52).

In addition to women's bodies, disabled bodies are also medicalized and subject to a "treatment model" (Biklen, 1988, p. 128). Biklen (1988) writes:

> People with disabilities are institutionalized, segregated and undereducated, socially rejected, physically excluded from public places, and unemployed. Any other group subjected to these circumstances would most likely be characterized as a minority. Yet the more common tendency has been to view people with disabilities as (a) victimized by a disabling condition and (b) in need of treatment—not of rights (p.

128).

This medicalization of disability persists today, with people who have a disability regarded "more as a 'patient' than an object of discrimination" (Biklen, 1988, p. 128). Because disabled bodies are understood differently than able bodies, and because bodies are considered to be within the realm of the medical model, people who have a disability are quickly medicalized. Biklen continues to note that people who have a disability may require certain services "such as treatment...or adaptive help" (p. 128), but this is not abnormal—indeed, most people, whether able-bodied or disabled, will require different types of services throughout the course of their lives. However, this perceived difference is used to medicalize those who have a disability and transform each into a "perpetual clinical subject" (Biklen, 1988, p. 128).

Survivors of sexual assault often seek or are referred to counselling or psychiatric services, which are part of the medical model. The goal of these services is to treat and improve a person's mental health—an important consideration in the aftermath of a sexual assault. In addition to psychologists and psychiatrists, survivors of sexual assault will encounter medical doctors and nurses if they go to an emergency room after they have been assaulted. Many survivors encounter the medical model following an assault, simply due to the normalized belief that medical professionals should be trusted to treat anything related to the body.

In situations where survivors of sexual assault who have a developmental disability are able to access some type of mental health support, practitioners who adhere to the medical model are typically entrusted with their treatment. Shames (2006) notes, from the perspective of the medical model, among people who have a developmental disability,

> ...their intellectual systems, memory, ability to abstract, and ability to perceive patterns of events, as well as their receptive and expressive linguistic skills and social competence, may be affected. The occurrence and degree of such disabilities vary from diagnosis to diagnosis and from person to person within each category. But...their emotional systems...are still intact and operating. They "feel," and suffer psychological pain. They know frustration, a sense of isolation, and a lowered self-esteem. Such individuals and their families are in need of and could also benefit from counseling (p. 142).

Shames identifies some of the differences a counsellor would likely encounter in treating an individual who has a developmental disability as opposed to a non-disabled person. However, there is a lack of research on how best to serve people with disabilities in the field of psychology, and clinicians often have little training in this area (Artman & Daniels, 2010, pp. 442-443). Furthermore, if a counsellor is uncomfortable with discussing sexuality or sexual assault, they may "enlarge conversational control and sometimes avoid the subject rather than helping clients to take charge" (McCarthy, 2002 as cited in van Nijnatten & Heestermans, 2012, p. 100).

Critiques of the medical model by non-disabled patients and patient advocates often centre on the lack of positive doctor-patient relationships, and the impersonal nature of these relationships. Hendrickson (2009) writes about a number of focus groups in which Ontario women detailed their frustrations with medical providers, mentioning that "doctors rush through appointments and do not take the time to listen, are sometimes insensitive, even disrespectful, of women's religious beliefs and ways of dressing, and are unaware of the values and customs of different cultures" (p. 254). The women who participated in this focus group stated that doctors should improve their active listening skills, provide more information overall, and provide information and relevant materials that are easy to understand (Hendrickson, 2009, pp. 253-255).

In addition to these concerns, patient advocates criticize the medical model for not taking into account the social factors that may influence a patient's life or health. Indeed, the medical model emphasizes mind-body dualism—the belief that the mind and body are separate in every way—in medical treatment (Todd, 1989, p. 13). However, mind-body dualism does not account for the health-related experiences of many women who have a developmental disability. Among some individuals who have a developmental disability, pain related to illness, trauma, or other "medical" issues may be expressed not through words, but through behaviour. For example, if a person is in pain because of an infection, they may react with stubborn or even "destructive" behaviour instead of verbalizing their discomfort (Lunsky et al., 2009, pp. 156-157). If a medical professional employs the concept of mind-body dualism, "troublesome" behaviour may be "misdiagnosed as 'psychiatric'" leading to the prescription of psychotropic medication instead of proper diagnosis and required medical treatment for the underlying health issue (Lunsky et al., 2009, p. 163).

Mind-body dualism also affects patients through the belief that medicine is objective and therefore factual, whereas a patient's "experiential knowledge" is subjective and therefore "not valid" (Lorentzen, 2008, p. 58). Despite this omnipresent attitude, the medical discipline is not objective. Riessman (1983) points out that "medicine is a social enterprise, not merely a scientific one" (p. 49). Lorentzen (2008) claims that: "within medical power relations, physicians who advance medical truth claims do so based on an assumption of objective scientific medical knowledge that can lead them to discount the embodied and empathic experiential knowledge of patients" (p. 58). Any feelings or influences from a patient's own life are seen as unreliable and are ignored in the interest of medical "fact." Additionally, because of the prioritization of scientific "fact," the medical model is less likely to consider the impact of social factors, such as gender and disability, on a person's health (Artman & Daniels, 2010, p. 443).

Women sometimes choose to trust their personal interpretation of their experiences over the privileging of medical “truths” and interpretations of their doctors, "despite physicians' attempts...to ignore, discount or repudiate women's knowledge of their bodies" (Lorentzen, 2008, p. 58). Though Lorentzen (2008) notes that many women demonstrate agency by challenging and contradicting medical professionals, the medical model's existing power structure means that a patient may not feel as though she has the ability or authority to do this, particularly if a woman has not had "extensive experience within medical interactions" (p. 61). Considering survivors of sexual violence, research on their agency within the medical model is lacking (Greeson & Campbell, 2011, p. 583). Furthermore, because the medical model treats all who come to them—including survivors of sexual assault—as though they are "sick" and require treatment or a cure, patients "have lost some control over their lives and normal routine activities, and this control is in part transferred to the doctor. Controversy exists over just how much control patients should retain over their treatment and thus their lives" (Todd, 1989, p. 4). This loss of control is another critique of the medical model, particularly by those who advocate for sexual assault survivors (Ontario Coalition of Rape Crisis Centres, 2014). Additionally, a survivor having control over her healing process is related to less PTSD symptom severity (Ullman et al., 2007, p. 829).

In some cases, criticism of the medical model led to changes within the system, as well as the development of alternatives to this model. Many areas within North America have introduced Sexual Assault Nurse Examiner (SANE) programs in order to improve the treatment of sexual assault survivors who visit emergency rooms. As defined by Greeson and Campbell (2011), SANEs are "highly trained forensic nurses who specialize in providing comprehensive care to rape survivors, attend to survivors' physical and mental health needs, and collect forensic evidence" (p. 583). This job description in and of itself demonstrates that SANE programs are very different from traditional care for survivors in hospital emergency departments (Greeson & Campbell, 2011, p. 593). When a survivor is treated by a SANE, there are a number of advantages: wait times are typically shorter; the examination process is explained to help reduce re-victimization; examinations are done faster and with greater care for preserving forensic evidence; and, subsequently, legal cases are more successful because of the SANE's expertise in collecting evidence and providing testimony—tasks that non-SANE practitioners are often reluctant to perform (Maier, 2008, p. 790; Martin, 2005, pp. 73, 80-82, 91).

Despite the goal to improve survivors' care, SANE programs are not always effective. The unreliability of SANE services was highlighted in a high-profile incident in 2010, in which a sexual assault survivor who arrived at The Ottawa Hospital's Civic campus was told that no SANEs were available, and that she would either have to return later or drive out of town for treatment (Taylor, 2010). This occurred despite the statements outlined in the city's Sexual Assault Protocol, which state that their SANE program will operate 24 hours a day, seven days a week, 365 days a year; that when a survivor arrives at the emergency department, they will be asked if they wish to see a SANE; that the SANE will then be contacted; and that the SANE will arrive within 45 minutes of being paged (Ottawa Sexual Assault Protocol, 2006). This was not an isolated occurrence; SANE programs across Ontario experience similar shortages (Taylor, 2010). In addition to staff shortages in already-established programs, not all communities have SANE programs, which may be due to hospitals' reluctance to establish, fund and administer them (Martin, 2005, p. 92). Though the SANE model provides treatment that is more skilled and compassionate due to the practitioners' specific training, they cannot be effective unless they are implemented according to the policy and prioritized by health care systems (Maier, 2008, p. 790; Martin, 2005, pp. 91-92). Furthermore, the SANE model only affects survivors who visit emergency rooms after they have been assaulted; it does not address further concerns within the medical model.

Lastly, there is no publicly available information to suggest that SANEs in Ontario receive training specific to survivors of sexual assault who have a developmental disability. Macdonald (2007) notes that a "co-existing medical problem" is a criterion for a SANE to refer survivors to a doctor (p. 11). Since the medical model constructs disability as a medical problem, whether or not the disability itself affects the person's health, a person with a disability may be referred to a doctor when seeking care from a SANE program. SANEs are trained to prevent or minimize re-victimization, but there is no guarantee that the doctor a survivor is referred to would follow the same guidelines.

The Feminist Support Model

Feminist support work is an alternative response to sexual assault that evolved in response to criticisms of the medical model and emerged through the rape crisis movement of the 1970s (Johnson & Dawson, 2011, pp. 118-119). Instead of treating women who have experienced sexual assault as though they are “sick” and need to be cured, as the medical model does, feminist support work aims to put women back in control of their lives by supporting and empowering them, thereby alleviating the risk of secondary victimization (Johnson & Dawson, 2011, p. 119; Martin, 2005, p. 110; Ontario Coalition of Rape Crisis

Centres, 2014). Rather than considering survivors as victims in need of treatment, the feminist support work model considers women's varied reactions to sexual assault to be "normal" responses to a traumatic event (Ontario Coalition of Rape Crisis Centres, 2015). This is in stark contrast to the medical model's view, which will often medicalize a survivor's reaction—for example, by diagnosing it as a disorder, such as PTSD. Furthermore, by asserting the belief that survivors should be supported in their experiences and their personal decisions, and by focusing on their right to determine their own course of healing, power is given back to the survivor. Having their sense of power and control restored after a sexual assault addresses critics' concerns regarding the medical model's power imbalance and can also be healing in and of itself.

Another way in which sexual assault support centres differ from other responses to sexual assault is that:

> …they are committed to believing women in order to counter the skepticism they met from almost every other corner; to creating empowerment; to supporting rather than counselling; and to defining rape as unwanted sexual activity, no matter how the law defined it or the context in which it occurred (Johnson & Dawson, 2011, p. 119).

As it has been detailed throughout this chapter, other responses to sexual assault often re-victimize survivors and can leave them more hurt than healed (Greeson & Campbell, 2011, p. 582). With the exception of SANEs, there is no guarantee that a doctor, nurse, psychologist or other medical professional will be sympathetic to a survivor of sexual assault; indeed, they may participate in re-victimization. Feminist support work resists this treatment of survivors and aims to counter these failures by providing an environment in which survivors feel safe, believed, trusted and respected by each person they come in contact with.

Grassroots feminist support work is not the same as counselling, which is typically considered to be within the realm of the medical model. Though neither counselling nor support work are regulated professions in Ontario, the College of Registered Psychotherapists of Ontario (2015) states that counselling is closely related to the medicalized and provincially regulated practice of psychotherapy. As opposed to counsellors, who are often paid for their work, support workers are often volunteers, and support organizations rely heavily on these volunteers due to a lack of funding (Beres, Crow & Gotell, 2009, p. 137; Maier, 2011b, p. 1384). They are generally not required to hold a degree in psychology or social work; however, they are required by their respective organizations to complete extensive training before engaging with service users. These training sessions are often based on various anti-oppression feminist principles, including collective decision making, an intersectional approach and focussing on sexual assault as "power-based, gender-based, structurally supported and therefore political" (Ontario Coalition of Rape Crisis Centres, 2014). Despite the focus on support as an alternative to the medical model, some sexual assault centres do offer formal counselling from psychologists, therapists or social workers. Increasing professionalization of sexual assault and rape crisis centres has led to the hiring of professional counsellors, and an increasing number of service providers are now required by funders to hold a relevant degree (Beres et al., 2009; Maier, 2011a, p. 143). This professionalization can be linked back to the medical model, in that practitioners who operate outside of this model may not be seen by others—in this case, those providing funding—as legitimate and their approach as effective.

Of the texts that discuss sexual assault and developmental disability, many deal with prevention; however, the importance of sexual assault support services is largely unmentioned (Hingsburger, 1993; Hingsburger, 1995; Hollomotz, 2011; Schwier &

Hingsburger, 2000; Sobsey, 1994). Counselling and other medical model supports are sometimes discussed (Mansell, Sobsey, Wilgosh & Zawallich, 1996; Shames, 2006; Sobsey, 1994) though this on its own is inadequate, since medicalization is often resisted by both disability and feminist scholars. Because the medical model treats both women and people who have a developmental disability as "sick" and in need of treatment, services offered through this model tend to reflect these constructions.

The efficacy of feminist support work is notable—Campbell, Wasco, Ahrens, Sefl and Barnes (2001) found that 75 percent of women who accessed rape crisis centres as opposed to traditional services when seeking support considered it to be "healing" (p. 1250). However, Johnson and Dawson (2011) mention that though the rape crisis movement has been integrated in the larger feminist movement, "outside feminist circles, concern for victims of sexual assault has attracted much less support" than for victims of other violent crimes, such as intimate partner violence (p. 9). This is reflected in the lack of literature surrounding support services for women survivors who have a developmental disability.

Summary

Though sexual assault is common, survivors are often re-victimized by those in their personal lives as well as those who are employed to respond to sexual assault, such as medical professionals, law enforcement officials and the judicial system. Attitudes such as victim blaming and disbelief are upheld in part due to societal stereotypes regarding gender and sexuality. These ideals portray men as inherently sexual, aggressive and dominant and in charge of decisions around sexuality, whereas women are portrayed as passive and responsible for guarding their sexuality.

The sexual ideals that reinforce the injustice faced by survivors of sexual assault are magnified for women survivors who have a disability. Societal stereotypes construct them as helpless, asexual or hypersexual, not in need of sex education, and not able to be sexually assaulted. This occurs even though there is a higher prevalence of sexual assault among this population, which is even more pronounced among women who have developmental disabilities.

Many institutions have created responses to sexual assault and, when considering a survivor's well-being following an assault, the medical model's response has traditionally been prioritized. The medical model's dominance in Western society leads many survivors—and those close to them, such as caregivers—to trust them and turn to them first. Additionally, issues regarding mental health, including a survivor's mental health in the aftermath of a sexual assault, are medicalized and seen as something to be treated or cured. Through this model, whether a survivor is seeking care from a physician, a psychologist or another medical professional, they may be re-victimized. This might occur due to the power imbalance inherent in doctor-patient relations, or it may be due to the medical professional's personal attitudes regarding sexual assault. Sexual Assault Nurse Examiner (SANE) programs have been created to alleviate some of the concerns raised by patient advocates, however, these programs are not without limitations, and they only address survivors who go to a hospital with a SANE program in the days immediately following the assault.

The feminist support work model aims to eliminate the problems faced by survivors who encounter unsympathetic professionals in other areas of their life, including the re-victimization that can occur with the medical model. Feminist support workers are dedicated to believing and trusting survivors, as well as allowing survivors to determine their own path to healing, rather than pathologizing and "treating" them. Even though research has shown that survivors find feminist support work to be healing (Campbell et al., 2001, p. 1250), it is underfunded, which may create conflicts if a support organization needs to alter their mandate in order to secure funding dollars. Additionally, the research literature on sexual assault against people who have an intellectual disability seldom discusses support work, choosing instead to focus on prevention or endorse the medical model.

The concepts that have been discussed here will be elaborated upon in the following chapter, where the theoretical frameworks that underpin this research will be introduced.

Chapter 3—Theoretical Framework

This research takes a feminist social constructionist approach, informed especially by feminist disability studies. This chapter will first introduce the theory of social constructionism, with a discussion of how this framework has been adopted by scholars in feminist and disability studies. Furthermore, this research project is also influenced by intersectionality theory, which will be examined in the second half of the chapter. The importance of intersectionality when studying women survivors of sexual assault who have a developmental disability will be addressed.

Social Constructionism

Social constructionism is a broad field influenced by several disciplines, including sociology, psychology, philosophy and linguistics (Burr, 2003; Stam, 2001). Due to its wide scope, there is no one defining feature of social constructionism, and it is not a single, unified approach (Stam, 2001). Burr (2003) lists four key attitudes that inform a social constructionist approach and argues that ways of understanding are historically and culturally specific, knowledge is sustained by social processes and interactions, knowledge and social action are connected, and that taking a critical approach is essential to challenge knowledge that is taken for granted (pp. 2-5).

Rather than focusing on the physical world, social constructionism is concerned with how the world is understood, and with "the *meaning* humans create in our world" (Loseke, 2003, pp. 13-14). Humans categorize and label types of things or people, recognizing these categories and labels as real, fixed and uninfluenced by social factors (Loseke, 2003, p. 14; Weinberg, 2009, p. 283). However, there is nothing to guarantee that these categories or labels "correspond, in the positivist sense, with the things they are about" (Weinberg, 2009,

p. 295); indeed, they are constructed through social interactions and engagement with material realities (Howard & Hollander, 1997, p. 35; Loseke, 2003, pp. 14-15). Furthermore, social constructionists argue that the categories we create and the meanings we give them are important because this influences the way we act and react toward them (Loseke, 2003, pp. 15-16).

Most feminist theorists have applied social constructionism to the concept of gender, criticizing the notion of biologically determined, essential human traits that distinguish groups of people from one another (Howard & Hollander, 1997, p. 36; Kimmel, 2008b, p. 4; O'Dowd, 2003, p. 42). Rather than accepting the prevailing societal belief that gender and sex are inherently linked, they argue that "gender is not 'natural' but is instead accomplished through everyday behaviour" and interactions (Howard & Hollander, 1997, p. 36). Furthermore, the performance of gender does not take place "in a genderless vacuum" but within the context of a gendered world and gendered institutions (Kimmel, 2008b, p. 122). How gender is defined and accomplished changes depending on the historical or cultural context, including within a single culture at a single time, and also varies over the course of a person's life (Kimmel, 2008b, pp. 100-101; O'Dowd, 2003, p. 42).

Because gender and sex are widely perceived to be the same or, at least, linked, certain performances of gender are normalized and others are considered to be "wrong" (Howard & Hollander, 1997, p. 38). Masculinity is constructed in opposition to femininity, and masculinity—when performed by men—is held as the privileged norm (Kimmel, 2008b, pp. 102-103). It is expected that men will be masculine and women will be feminine, and when a person does not "pass" as one or the other, or is deemed to have "tricked" others when it is found that their sex and gender do not "match," they often face reactions of discomfort, disdain, mockery, and even violence (Howard & Hollander, 1997, p. 36-38; Kimmel, 2008b, pp. 118-120; Spade, 2011, pp. 8-10). "Passing" as male or female is complicated, as the ways in which people perform gender are often inconsistent; to "successfully" perform gender, however, "what is important is that the balance of one's actions is perceived as conforming" (Howard & Hollander, 1997, p. 37).

Because masculinity is constructed as the norm, it is often invisible. This invisibility allows for gendered situations that privilege masculinity to "masquerade" as gender neutral (Kimmel, 2008b, pp. 113-114). Gender neutrality therefore hides the structure that maintains masculine men as the norm, perpetuating gender inequality and gender differences (Acker, 1990). Furthermore, this norm means that: "the culturally appropriate ways of producing gender favor men's interests over those of women" (Pyke, 1996, p. 530).

The Social Construction of Disability

Just as feminist scholars have stated that gender is a socially constructed concept, critical disability theorists focus on the social construction of disability—commonly referred to as the "social model." According to this framework, disability should not be seen as a "pathology rooted in the individual" so much as a construction "built upon a variety of social and economic factors" (Matysiak, 1998, p. 9). Wendell (1989) writes that feminists should critique the notion that people who have a disability are "victims of nature or accident" (p. 246). She encourages feminist scholars to relate this concept to the social constructions of gender, stating "that if being biologically female is a disadvantage, it is because a social context makes it a disadvantage," not because it is inherently or "naturally" disadvantageous (Wendell, 1989, p. 246). Likewise, if having a disability is thought of as a disadvantage, it is because a social construct makes it so.

Because disability is socially constructed, it is not a static concept, and is therefore subject to change. As feminist disability scholar Susan Wendell (1989) states:

> Whether a particular physical condition is disabling changes with time and place, depending on such factors as social expectations, the state of technology and its availability to people in that condition, the educational system, architecture, attitudes towards physical appearance, and the pace of life. (If, for example, the pace of life increases without changes in other factors, more people become disabled simply because fewer people can keep up the "normal" pace.) (p. 246)

Since so many factors influence the perception and definition of disability, it cannot be conceptualized as a natural disadvantage.

Social constructionist disability scholars distinguish the concepts of "disability" and "impairment" from one another. They argue that impairment is an actual physical condition—for example, paraplegia—whereas disability is not an actual condition, but a product of society's dis-abling barriers, such as having only stairs instead of ramps or elevators (Shakespeare, 2006). This distinction shows that people are not disabled by their bodies, as mainstream understanding suggests, but that they are actually disabled by societal conditions (Oliver & Barnes, 2012, p. 22).

While the social construction of disability and the distinction between disability and impairment are valuable concepts, some are critical of the implied dichotomy. The concept "risks implying that impairment is not a problem" for some people (Shakespeare, 2006, p. 200). Shakespeare (2006) points out:

> For individuals with static impairments, which do not degenerate or cause medical complications, it may be possible to regard disability as entirely socially created. For those who have degenerative conditions which may cause premature death, or which any condition which involves pain and discomfort, it is harder to ignore the negative aspects of impairment. (p. 200)

People with degenerative or painful impairments may still require certain types of support—

for example, pain management or hospice care—even if all disabling societal barriers are removed. For these people, disability is not the only concern, as impairment itself presents challenges. Due to this, some scholars state that "disablism differs from sexism or racism, in that there is nothing intrinsically disadvantageous in having black skin or being female, whereas there are real drawbacks to having an impairment" (Shakespeare, 2000 as cited in Stalker, 2012, p. 124). However, the social model does not fully account for negative experiences of impairment. Shakespeare (2006) argues that "in everyday life it is very hard to distinguish clearly between the impact of impairment, and the impact of social barriers" (p. 201). The differentiation between impairment and disability is critical to the social model, though in order to uphold this theory, the interaction and overlap of these two categories is downplayed. Barnes (1998) argues that any focus on the interaction of these categories hearkens to the medical model and is antithetical to the political goals of the social model (p. 77). This oversimplification marginalizes people who believe that the social model does not entirely account for their experience. It also dismisses much of the work that critiques or expands upon the social model. Oliver and Barnes (2012) state that addressing the effects of impairment is not the purpose of the social model; nevertheless, the lack of focus on impairment reveals this theory's limitations (p. 23). The social model has been transformative within disability studies and it is a major theoretical framework informing this project; however, the criticisms regarding impairment will also be considered.

Social Construction and Developmental Disability

The field of disability studies has been accused of excluding people who have a developmental disability from both theory and theorizing, as well as from research (Stalker, 2012, p. 122). Stalker (2012) acknowledges that "most 'key' [disability studies] texts make little reference" to people who have a developmental disability (p. 123). Goodley (2001) writes that developmental disability is still assumed to be biological, despite scholars' focus on social constructionism and differentiation between impairment and disability (p. 211). British self-advocate Simone Aspis (as cited in Campbell & Oliver, 1996) is critical of the fact that many physically disabled scholars, who otherwise reject the medical model, continually rely on this model when discussing developmental disability (p. 97). Campbell and Oliver (1996) acknowledge Aspis' argument as to why the exclusion of developmental disability may occur:

> The lack of true collaboration between people with and without learning difficulties stems from a fear in the latter of being labelled 'stupid, thick, mental and mad' by the non-disabled public. Therefore if people with and without learning difficulties were seen together, the stereotype of disabled people as incapable would be enhanced (p. 97).

This suggests a hierarchy of ability even within disability studies and activism. People who have a developmental disability are not treated as equals by some disabled scholars and activists. By creating this distance, they are reproducing the social construction of people with developmental disabilities and contributing to further marginalization.

The relevance of social constructionism to those who have a developmental disability is contested. Those who argue in its favour point out that people who have developmental disabilities have been categorized in many different, often conflicting ways, and that these categorizations have been imposed on them by others (Rapley, 2004; Stalker, 2012, p. 127). The variation in the categorization across time and place, as well as its definition by non-disabled medical professionals, suggest that developmental disability is a social construct. Indeed, Rapley (2004) argues that developmental disability "might, rather than being a 'thing' like the measles virus, be an idea, or a historically contingent *way of talking* about people who appear to be in need of assistance and who are not very good at IQ tests" (p. 42). Among the greatest challenges that many individuals who have a disability face are socially constructed “perceptions that underestimate their potential and abilities” (Canadian Down Syndrome Society, 2007). These perceptions limit the available opportunities for people with developmental disabilities to participate in society as a non-disabled person would. Those who argue that developmental disability is socially constructed in much the same manner as physical disability affirm that the social model is just as important to people who have a developmental disability as it is to other disabled persons.

Those who are sceptical of social constructionism's usefulness for people who have a developmental disability point to physical disability scholars' reluctance—or outright refusal—to include issues surrounding developmental disability in their work. A divide in philosophies is evident from the very terms that physically disabled scholars and self-advocates who have developmental disabilities use to refer to themselves. A key tenet of the social model of disability is the use of the term "disabled," rather than "person with/who has a disability," signaling through language that people who have an impairment are dis-abled by societal factors and not by the impairment itself. Shakespeare (2006) writes that, due to the politicization of the term "disabled," those who say "person who has a disability" are assumed to be adherents of a more mainstream, medicalized approach that is not committed to social change (p. 199). However, given the history and effects of the dehumanization of people who have a developmental disability, many self-advocates prefer to reaffirm their humanity by using "people-first" language (Gillman, Swain & Heyman, 1997, p. 690; Taylor, 1996 as cited in Stalker, 2012, p. 125). This basic difference in which terms are preferred creates a divide between self-advocates and physically disabled scholars before collaboration even begins.

Social model scholars and activists—the majority of whom have physical disabilities—have been accused of not considering the experiences and realities of the lives of people who have developmental disabilities. Anastasiou and Kauffman (2011) argue that:

> [They] apply their specific view to other types of disabilities, some of which have no public voice at all—or a very weak one. In this endeavor, social constructionists do not speak for and by themselves; on the contrary, they speak on behalf of people with intellectual disabilities, autism, emotional or behavioral disorders, and others who do not share their particular type of disability. In doing so, they commit (perhaps unwittingly) the very act to which they have so strongly objected: others (i.e., people without disabilities) speaking for them (p. 377).

Essentially, physical disability scholars and activists enable and perpetuate the silencing of people who have a developmental disability by speaking for them. Furthermore, Aspis (as cited in Campbell & Oliver, 1996) states that people who have a developmental disability "are always asked to talk about advocacy and our impairments as though our barriers aren't disabling in the same way as [physically] disabled people" (p. 97). This attitude is linked to the continued application of the medical model to developmental disability by physically disabled activists. These assumptions inhibit the ability to apply social constructionism to developmental disability, and without the inclusion of people who have developmental disabilities themselves, the relevance of social constructionism cannot be accurately assessed.

Other critics' arguments focus on the difficulty of separating impairment and disability, as addressed previously in this chapter. Shakespeare (2006) argues that it is complicated to determine which aspects of a person's life are affected by impairment and which are affected by disability (p. 201). He uses the example of a disabled person who experiences depression, emphasizing that it is difficult to establish whether the depression was caused by her reaction to her impairment, by societal attitudes, or by other factors (p. 201). Shakespeare also notes that it is generally easier to accommodate people with physical or sensory impairments, and that the social model has not addressed the accommodation of people who have developmental disabilities, among other impairments (pp. 201-202). Stalker (2012) argues that some people who have developmental disabilities, like some people who have other impairments, will always need a certain level of support due to their impairment (pp. 130-131). The social model does not account for this. Furthermore, failure to recognize the influence of impairment may further isolate some people who have a developmental disability. Marks (1999) cautions against "erasing" differences related to impairment, emphasizing that disability scholars should instead "acknowledge, name and respect differences" (p. 619). Stalker (2012) argues that this erasure of difference may make it more difficult for people who have a developmental disability to obtain services or supports, causing them to experience additional discrimination (p. 130).

These criticisms do not entirely condemn social constructionism; instead, they show where the theory needs to adapt to account for a diversity of impairments. Without incorporating the concerns of people who have developmental disabilities, it will not be applied to its full potential. Further theorizing about and with people who have developmental disabilities must be undertaken in order to achieve inclusion (Stalker, 2012, p. 123).

Intersectionality

Intersectionality has become an increasingly popular theory in feminist scholarship (Staunæs & Søndergaard, 2011, p. 45). Defined as “the idea that race, class, gender, and sexuality [are] dominant factors that shape people's experiences and…are hierarchical, mutually reinforcing, and simultaneous" (Berger & Guidroz, 2009, p. 4), intersectionality can be seen as a means to avoid making generalizations about "women" as a group. Dill (1983) notes that even though the concept of sisterhood has successfully united white, middle-class feminists to work against patriarchy, this idea did nothing to engage women of colour and working class women, not to mention other identities (p. 25). Intersectionality seeks to recognize that all aspects of a woman's personal experiences of oppression are inextricably linked, and aims to incorporate this in research and activism.

The intersections considered by scholars have expanded over the years. The theory initially included only gender, race and class as intersections, broadening to incorporate sexuality, ethnicity, nation and age in later years (Berger & Guidroz, 2009, p. 1). The theory commits itself to examining how multiple intersections of oppression shape one's experiences, yet various texts on the topic often omit or ignore the influence of some intersections, especially disability (Garland-Thomson, 2001, p. i; Nash, 2008, p. 7), despite calls for a feminist disability theory as early as 25 years ago (Garland-Thomson, 2001; Wendell, 1989).

By considering the intersection of disability and gender, much is revealed about both categories of oppression. Both disabled bodies and women's bodies "are cast as deviant and inferior; both are excluded from full participation in public as well as economic life; both are defined in opposition to a norm that is assumed to possess natural physical superiority" (Garland-Thomson, 2001, p. 7). These basic similarities between disability and gender suggest that feminist analysis would be useful within disability studies, and vice versa. However, disability itself "disrupts the unity of the category 'woman' and challenges the primacy of gender" (Garland-Thomson, 2001, p. 16). Feminists who have not yet started to incorporate an intersectional analysis in their work may not acknowledge the influence of disability in the way Garland-Thomson (2001) outlines it. Indeed, ableist societal structures mean that feminist activists often fail to make necessary accommodations that allow disabled women to fully participate (Garland-Thomson, 2001, p. 6).

The importance of feminist researchers considering the intersection of disability is evident when considering sexual assault—an issue of primary concern for feminists. It is not enough to simply study the experiences of "women" and "people who have developmental disabilities" as general categories. Both women and people who have developmental disabilities experience higher rates of sexual assault than men and able-bodied people. Examining how this affects women who have a developmental disability—including other identities they may have—is paramount for feminist and disability studies researchers. As Staunæs & Søndergaard (2011) note, "the effects of these categories cannot be understood in isolation from each other" (p. 45). Without considering the ways in which gender and disability interact and reinforce each other in the lives of survivors, research on the subject of sexual assault will be incomplete.

Other intersections also influence the lives of women who have a developmental disability, and this must be considered throughout the research process. An intersectional analysis of approaches to sexual assault support must acknowledge the oppression perpetrated by medicalization and the medical model. Eugenics policies in Canada, as well as other countries, led to the forced sterilization of women of colour and women with disabilities for much of the twentieth century (Malacrida, 2005; Ralstin-Lewis, 2005; Wahlsten, 1997). Those who supported eugenics believed that the "feeble-minded" were a threat to society; “a central element in the degeneracy or deterioration of the race” (Rose, 1999, p. 213). Therefore, institutions across Canada segregated people with developmental disabilities from the rest of society (Malacrida, 2005, p. 77; Rossiter & Clarkson, 2013). Women of colour have also been targeted through eugenics—for example, the United States has sanctioned forced sterilization of Japanese women, Mexican immigrants and Chicanas, indigenous women and Puerto Rican women (Rojas Durazo, 2006, p. 185). The United States’ Indian Health Service forcibly administered the contraceptive Depo-Provera to indigenous women and girls with developmental disabilities, including before it was approved by the Federal Drug Administration (Ralstin-Lewis, 2005, p. 72; Smith, 2005, p. 92). Sterilization abuse continues in other forms today, as well. Several European countries require transgender people to be sterilized in order to have their gender legally recognized (Amnesty International, 2014). The international organization Project Prevention pays (often racialized, disabled, and poor) women small sums of money to be sterilized (Bierria, 2007, p. 154; Smith, 2005, pp. 86-87). An intersectional analysis reveals the violent history of medicalization and how this has affected many groups of marginalized women. This history necessitates a response to sexual assault that exists outside of the medical model.

It is important to use an intersectional lens to highlight the limitations of grassroots sexual assault support services. Many anti-violence organizations are funded, wholly or in part, by the state or corporations, and their work must therefore remain within certain boundaries (Smith, 2011, pp. xiii-xiv). The regulations imposed by these funders disproportionately affect people of colour, immigrants, people living in poverty, and disabled people. Additionally, the sterilization abuses discussed above are a result of state policies. Therefore, many feminist organizations are supported by—and help to reinforce—

the very systems their service users are oppressed by, and this concerns many activists (Smith, 2011, pp. xiii-xiv). Due to their policies, some feminist support services themselves have been criticized as racist, transphobic, homophobic, classist and ableist (Koyama, 2006; Munson, 2011; Rojas Durazo, 2007). In many instances, shelters and support organizations that were supposed to be "inclusive" have turned away or otherwise mistreated women who have disabilities or illnesses, women who do not speak English, immigrants, sex workers, addicts, trans and queer women, poor and working class women, and single mothers (Koyama, 2006; Munson, 2011; Rojas Durazo, 2007). This is often due to these services' overreliance on state systems for financial and law enforcement-related support (Koyama, 2006, p. 215; Rojas Durazo, 2007, pp. 116-118). Furthermore, these organizations may subscribe to a "colour-blind" ideology, defined by Frankenberg (1993) as "a mode of thinking about race organized around an effort to not 'see,' or at any rate not to acknowledge, race differences" (p. 142). As a result of colour-blindness, "many white people act and speak in ways that discursively reinforce racial inequality without recognizing the moral implications of their words and actions. Regardless of whether or not they are aware, the consequence is racist discourse" (Alegria, 2014, p. 244).

While the need for alternatives to the medical model has been demonstrated, if grassroots and feminist support services continue to follow a model that is not radically different from that of the state-supported medical model, oppression will continue to be reproduced. Therefore, any analysis of feminist support services must consider intersectionality and how oppression is reproduced or resisted by sexual assault support organizations and the services they offer.

Summary

Social constructionism is concerned with how meaning is created, how the world is understood to exist, and the shifting nature of these understandings. The social constructionist approach to gender argues that gender is not determined by natural or inherent characteristics but by social interactions. Socially constructed ideas of masculinity and femininity uphold masculine men as dominant and the norm. Furthermore, the social constructionist approach to disability rejects the idea of disability as pathological and inherent in a person, arguing that disability is a result of dis-abling societal attitudes and barriers. The relevance of this theory to people who have a developmental disability is contested, as physical disability scholars often omit analyses of developmental disability from their work. Additionally, while some argue that it is more difficult to separate the effects of impairment and disability for those who have a developmental disability, thereby limiting the social model's usefulness, others argue that developmental disability is constructed in much the same way as physical disability (Campbell & Oliver, 1996, p. 97).

As demonstrated above, intersections of oppression greatly influence how marginalized women experience their lives, particularly regarding sexual assault. Without the theory of intersectionality, feminist theory fails to account for many women—particularly those who have traditionally been excluded from feminist analyses, as disabled women have. When studying sexual assault support services, it is important to consider survivors' intersectional identities and the criticisms of these services' inclusivity or lack thereof.

Chapter 4—Methodology

This chapter will reintroduce the research questions and outline the qualitative methodology that is used in this social constructionist, intersectional study, which is feminist in-depth interviewing. This chapter also describes the processes used to recruit research participants, methods of data collection and data analysis, as well as the study's limitations.

Research Questions

The sexual assault support model has largely been overlooked in service provision for survivors of sexual assault who have a developmental disability, and the medical model favoured. Furthermore, feminist sexual assault support services often exclude developmental disability in an intersectional analysis. To address this gap, disability support workers and sexual assault support workers in a medium-sized city in Ontario were interviewed, with the goal of analyzing how each construct women survivors of sexual assault who have a developmental disability. The research questions are:

- How do sexual assault support workers construct women who have developmental disabilities, and how does their service delivery reflect these constructions?
- How do organizations serving people who have developmental disabilities construct women survivors of sexual assault, and how does their service delivery reflect these constructions?

Methodology

This study is guided by social constructionism and intersectionality theory, and utilizes a qualitative research methodology and feminist in-depth interviewing method. Sarantakos (2005) notes that qualitative methodology is appropriate when the researcher aims to "capture the meaning and regularities of social action" (p. 134). Qualitative research methodology was the most appropriate choice for this research project as it gives the researcher the opportunity to collect and present information from the perspective of the subjective realities of disability and sexual assault support workers, and the meanings they attach to these realities. Furthermore, qualitative methodology allows the researcher to explore multiple intersections of oppression, in ways that make sense to the support workers responding to them.

While there is arguably no distinct feminist methodology (Sarantakos, 2005, pp. 70-71), integrating feminist approaches to qualitative methodology was fundamental to this research process. Feminist research pays particular attention to gender, differentiating it from qualitative research that does not consider gender or prioritize women's experiences (Ramazanoğlu & Holland, 2002, pp. 15-17). Feminist scholars who adhere to a qualitative approach are concerned with the moral, social and political implications of their research, a feature shared with certain other social research traditions, such as disability studies (Ramazanoğlu & Holland, 2002, pp. 10-11, 15-17). A feminist qualitative approach emphasizes the importance of obtaining information directly from research participants and inviting them to elaborate and use their own words (Reinharz, 1992, p. 19). Using a qualitative approach, this research project examines the work of service providers by obtaining firsthand information about how they experience their work and construct the women they are mandated to assist.

Qualitative research methodology allows social constructionism and intersectionality to be applied in this research. It also leads to the choice of feminist in-depth interviewing as the method, which is appropriate for understanding the constructions of women survivors of sexual violence who have a developmental disability.

Feminist In-Depth Interviewing

This research was guided by the concept of feminist in-depth interviewing, which enables researchers to access "knowledge of the diversity of women's realities that often lie hidden and unarticulated" (Hesse-Biber, 2007, p. 113). By interviewing service providers, the goal was to obtain information that otherwise might not be uncovered regarding their social construction of women survivors of sexual assault who have developmental disabilities.

Traditional research involving interviews is often conducted within an andro-centric framework that maintains the othering of women and other marginalized people (Code, 1995, p. 15-17). Conversely, feminist interviewing centres the experiences of women and pays particular attention to how patriarchy—and, increasingly, other forms of oppression—influence these experiences (Code, 1995, p. 15; DeVault, 1990, p. 96; Olesen, 2000, pp. 216, 220-222). Feminist interviewers typically conduct unstructured or semi-structured interviews, as highly structured interviews have the potential to unintentionally silence interviewees on issues important to them (Hesse-Biber, 2007, p. 119). They ask open-ended questions and use probes to obtain further information, questions that are intended to reveal the lived experiences of women and other marginalized people (Hesse-Biber, 2007, pp. 117-119, 127; Reinharz, 1992, p. 18). These lived experiences are often "ignored, censored, and suppressed" in traditional research in which response categories are constructed in advance with little or no input from the lived realities of marginalized people (DeVault, 1996, p. 32). Semi-structured interviews chosen for this project provide some structure in order for the researcher to address particular issues with interviewees (Hesse-Biber, 2007, p. 121), while offering interviewees the opportunity to raise and elaborate on issues they consider relevant

(Reinharz, 1992, p. 18).

Feminist approaches to methodology stress the importance of research for social and political change (Ramazanoğlu & Holland, 2002, p. 16). Indeed, feminist researchers have "historically…used interviews for social reform purposes" (Reinharz, 1992, p. 22). By centering women's experiences, feminist interviews enable the production of research that is "for rather than merely about women" (Olesen, 2000, p. 215), thereby producing research that has the potential to affect change.

Feminist researchers acknowledge that interviews do not take place in a vacuum, nor are they devoid of power, and are undertaken within a socially constructed context (Alvesson & Sköldberg, 2009, p. 11; Best, 2003, p. 895). As a result, feminist interviewers emphasize the importance of reflexivity, the practice of recognizing and analyzing how their identities and those of the interviewees affect the research process, the questions they pose and the way they interpret data (Alvesson & Sköldberg, 2009, p. 79; Hesse-Biber, 2007, pp. 129, 131; Olesen, 2000, p. 226). The identities of the interviewer and interviewees can also influence whether interviewees feel comfortable with or trust the researcher. Trust, or a lack thereof, can affect what information the interviewee is willing to provide (Best, 2003, p. 896; Reinharz, 1992, pp. 29-30). Feminist interviewers do not believe that practicing reflexivity precludes "objective" research; rather, they argue that calling privilege into question "maximizes objectivity" and "ensures that the respondent's voice is represented, listened to, and understood throughout the research process" (Hesse-Biber, 2007, p. 131).

Data Collection

Research Participants

I chose two separate groups of people to be interviewed: sexual assault support workers, as well as representatives from organizations that serve people who have developmental disabilities. I only selected organizations that provide services in English. In order to avoid overrepresentation of any organization, I initially requested that two individuals from each organization participate in an interview. People with different roles were requested for the interviews in order to gather information from those who create programming as well as those who are involved in the provision of services. I obtained approval from the university's Research Ethics Board (Appendix A).

I asked two sexual assault support organizations to participate in this study, choosing this number because there are very few of this type of organization in the city selected for this research project. I initially contacted the organizations by phone and then sent a recruitment letter by e-mail (Appendix B). One organization agreed to participate, while the other declined to participate due to a lack of internal resources. Initially, I intended to interview two people from each organization. Due to the fact that only one organization agreed to participate, I requested two to four interviewees from this organization. I asked the organization to distribute the recruitment information letter to its employees and volunteers in order to recruit participants. The recruitment process for this organization was long and ultimately, only two individuals agreed to be interviewed. One participant is a volunteer support worker, while the other is an administrator who also does support work. Prior to their involvement with their current organization, they each worked with other organizations that address violence against women. Their current organization has a standardized training program that is mandatory for all members of the organization. This training addresses disability and developmental disability to an extent, which will be discussed in further detail in Chapters 5 and 6. Any additional training may or may not address disability and is not standardized or, typically, mandatory.

I chose three organizations that provide services for people who have developmental disabilities to participate in this study. There are also few organizations of this type in the city selected for this research project, although there are more of these than there are sexual assault support organizations. The organizations I selected provide a number of services, including but not limited to employment supports, independent and community living supports, and social and recreational opportunities. I initially contacted the organizations by phone and then sent a recruitment letter by e-mail (Appendix B). All three organizations agreed to participate. I asked the organizations to distribute the recruitment information letter to their employees in order to recruit participants. Two people from each organization responded to the recruitment letter and agreed to participate. No two people from the same organization had the same role, and they each had different professional and educational backgrounds. At each organization, one interviewee held a senior administrative position and the other held a lower administrative position, though all provided some level of direct service to women who have a developmental disability. Some of the workers are social workers, and all hold paid positions. All three organizations have mandatory standardized training on sexual assault for all employees and volunteers.

Interviewing Process

I conducted interviews from May to October 2013. On average, the interviews lasted approximately one hour, with the shortest lasting about half an hour and the longest about two hours. The interviews were held at times and locations chosen by the interviewees, usually at their agencies. In order to ensure accuracy, all of the interviews were recorded with an audio recorder and transcribed afterward.

The interview process was guided by a set of specific questions, allowing me to address particular issues and the interviewee some flexibility in describing their own lived experiences (Bryman & Teevan, 2005, p. 71; Hesse-Biber, 2007, p. 115-116). I used two separate interview guides—one for the interviews with sexual assault support workers and another for the interviews with representatives of organizations for people who have developmental disabilities (Appendix C, Appendix D). Some examples of initial questions from the interview guide for sexual assault support workers are:

- What different communities in your city do you work with, or work to accommodate?
- Have any women who have developmental disabilities accessed your services?
- Does your organization offer any services specifically targeted toward survivors who have a developmental disability?

Some examples of initial questions for disability support workers are:

- What type of services or programming does your organization offer specifically for women who have a developmental disability?
- How do you think a woman's experience of developmental disability might affect her experience of sexual assault?
- If a woman who has a developmental disability disclosed to you that she had been sexually assaulted, what would you do?
- Are you familiar with the idea of sexual assault support services?
- What obstacles do you think you might encounter when assisting a woman with accessing sexual assault support services?

Ethical Considerations

To ensure confidentiality and anonymity, and due to the small number of sexual assault support and disability support services in the city selected for this project, the city and the names of the organizations are kept confidential, and all interviewees are anonymous. I assigned pseudonyms to the participants and removed information that could potentially identify the interviewees or their organizations. I replaced any terms specific to certain organizations with general terminology. In order to further protect interviewees' anonymity, I stored data related to the interviews on two password protected devices, and the files themselves are also password protected.

Before each interview began, I reviewed the purpose of the study and an informed consent form (Appendix E) with the interviewees. I assured the interviewees that they had the right to refuse to answer any questions. Participants were given the opportunity to review and verify the transcript from their interview, though none of the interviewees chose to do so. I also informed the interviewees that they had the right to withdraw their participation from the study at any point in time and that, if they did, all data related to them would be destroyed. No participants withdrew their participation.

It was important to consider the possibility of the interviewees experiencing psychological or emotional discomfort during the interviews, due to the emotional nature of many discussions about sexual assault. At the beginning of the interviews with disability support workers, I presented the interviewees with a list of sexual assault support services in their community in the event that they or someone they knew needed to access the services after the interview. It was not necessary to provide this information to sexual assault support workers as they are trained to provide this support and routinely refer service users to other support services in the community. I assured all interviewees that they had the right to refuse to answer any questions for any reason, or to end the interview at any time.

The interviewees did not receive any direct compensation for their participation in the study. Once the study is completed, I will provide the interviewees with a report summarizing the results. I have also offered to give a presentation summarizing the findings to each organization involved.

Data Analysis

After conducting the interviews, I transcribed the audio recordings word for word, with the exception being the elimination of irrelevant filler speech. When significant portions of filler speech were removed (as opposed to a single instance of "but" or "um," for example), ellipses are used to denote this. Filler speech was kept in the transcripts when it was deemed to be relevant. Furthermore, relevant verbal and non-verbal cues, particularly intonation and pauses in speech, were noted in italics and round brackets. Information intended to give context or clarify the interviewee's comments is included in square brackets—for example, if the interviewee has used an acronym to refer to a policy or organization, the full name will be noted in square brackets. In order to protect confidentiality, when an interviewee has used a term specific to their organization, a generalized term replaces it in square brackets.

I chose an inductive approach for this project. I looked for themes and patterns that emerged from interviewees' responses and used open, eclectic coding to analyze the interview transcripts. Eclectic coding is a form of open coding in which the researcher utilizes several different coding methods (Saldaña, 2013, p. 188). Specific types of coding used included in vivo coding, where the code itself is something the interviewee said; emotion coding, where the code represents an emotion that the interviewee expressed; subcoding, where lower order codes were categorized under associated higher order codes; and simultaneous coding, where one statement may correspond to two or more codes (Saldaña, 2013, pp. 77-105). Codes developed from the data, reflecting relevant and recurring topics from the interviews. In some cases, codes reflected questions the interviewees were asked, though data associated with that code may have come from anywhere in the interview or interviews. Other inductive codes were based on particular constructions that were reinforced or resisted during the interviews. Throughout the analysis process, I refined the codes and used them to re-code the data.

Limitations

A main limitation of this research project is that even though the focus is on support services for women survivors who have developmental disabilities, service providers were interviewed, not the service users themselves. The service users' standpoints are therefore absent from this research and how they experienced and perceived ways in which they were constructed by service providers cannot be inferred.

The small sample size was an additional limitation, though there are a limited number of organizations providing disability support or sexual assault support services in the city selected for this project. As one sexual assault support organization declined to participate, only one such organization is represented in the data. It is possible that workers from a different organization would have offered different perspectives.

Focusing solely on services in one city is another limitation. Cities, towns and rural areas all have different resources and networks and the size of a community determines in part the availability and quality of services. Furthermore, the delivery of health and social services is a provincial/territorial responsibility; therefore a similar study in a city of a different size or in a different part of the country may yield different results.

Reflexivity

It was important to consider the effect my identity as a white, middle-class woman and a university student had on the research process. Best (2003) notes that her identity as a middle-class white researcher interviewing young women of colour prompted her interviewees to engage in "a careful shaping and (re)working of their narrative" (p. 900). She notes that this reworking took place subtly throughout her interviews. The performance of gender, whiteness and the influence of class privilege also affect what information is shared and how it is conveyed (Best, 2003, p. 906-907).

As a woman and a women's studies student, it is possible that male interviewees were more guarded in their responses than they would have been with a male researcher or even someone studying in a different field. They may have felt pressure to use particular language because of these aspects of my identity (Gatrell, 2006, p. 244).

As a young person, my age may have helped to establish rapport with younger interviewees. In my experience, young people are often wary of ageism perpetrated by older people, so it is possible that they were more comfortable with me than they would have been with an older researcher. On the other hand, my age may have been a disadvantage with older interviewees, as I may have been seen as less experienced or knowledgeable.

Hesse-Biber (2007) uses an example of being both an “insider” and “outsider” in an interview with a fitness trainer—she is an “insider” because she is a member of this trainer’s gym, but an “outsider” because she is “a researcher, who inhabits a [different] social world” (Hesse-Biber, 2007, p. 114). To the sexual assault support workers whom I interviewed, I was an insider because I identify as a woman and have prior knowledge of and experience doing feminist work. I was also an insider with the disability workers due to the fact that I have volunteered with different organizations serving people who have developmental disabilities. In both cases, this may have helped to increase the interviewees' trust in me. I attempted to establish or maintain insider status during the interviews by listening for terms specific to the interviewees' organizations and adopting their terminology. However, there were also ways in which I was an outsider. I have not had the same jobs, responsibilities, or training as the interviewees; they possess experiential knowledge that I do not. There were also instances in which I could sense some distrust among the interviewees due to my status as an outsider. This seemed to be due to a fear of potentially facing repercussions for the information and opinions they were sharing.

My education may have been advantageous and disadvantageous. Canadian society privileges formal education, so this gave me credibility. However, it is possible that I lost some credibility among disability support workers due to being a student in women's studies rather than a field they were more familiar with, such as social work. Furthermore, as a researcher, my knowledge may come more from theory than practice. This has the potential to present a barrier with sexual assault support workers, as grassroots feminist activists may be wary of academic feminism. This may also have been a barrier for older workers, who have accumulated practical knowledge over a long period of time.

Each of these identities and experiences must be considered alongside each other. They are mutually reinforcing, and no one can be disassociated from another. Due to the multiple identities of the interviewer and interviewees, power relations and insider/outsider status can and did shift continually throughout the course of the interviews (Best, 2003, p. 907). Interviews are social events that take place in a socially constructed context; as such, I analyzed constructions that could have been constructed differently by the same participants in a different context. Furthermore, I chose what questions to ask, how to analyze the data, and what to include and exclude in the data analysis. Another researcher could make different decisions in this process and come to different conclusions.

Not only do I have to consider privilege in relation to the interviewees, but also in relation to the people this research is intended to benefit. The interviewees and I do not have developmental disabilities, yet we discussed issues that profoundly affect the lives of women who have developmental disabilities. The interviewees were given a chance to speak, and I am given this platform from which to write, but the voices of those most affected by these discussions are not heard. I am obligated to always put their interests at the forefront.

In the following chapter, I present the findings produced from this research process.

Chapter 5—Results

During the data analysis process, three broad themes emerged from the data and several sub-themes fall under each of these categories. This chapter will be divided into three sections, one for each theme. The first addresses the many ways that sexual assault support workers and disability support workers resist and reproduce ableist constructions, often simultaneously. The second theme pertains to how both groups of workers engage with what I have identified as re-victimizing constructions and the third explores how both groups of workers privilege certain identities over others within intersectional analyses or lack thereof. Though these three categories are most relevant to the research questions, many themes within these categories overlap. See Table 1 for themes, subthemes and examples of indicators.

Resisting and Reproducing Ableist Constructions

This theme addresses the interviewees' expressions of ableist social constructions, dealing with the commonly held belief that people who have a developmental disability cannot or should not communicate for themselves, particularly in the context of a legislated mandatory reporting policy, different standards and expectations regarding confidentiality, vulnerablizing constructions, and medicalization.

"Not Speaking For, but Finding Ways to Speak With": Service Users Communicating for Themselves

The above quotation, spoken by sexual assault support worker Jenna during the interview, demonstrates an ideal that both groups of workers articulated. The desire to speak and work with service users, rather than speaking for them or acting on their behalf, was a

Table 1: Themes and Examples of Indicators

Themes	Indicators
Resisting and Reproducing Ableist Constructions	
1. "Not Speaking **For,** but Finding Ways to Speak With": Service Users Communicating for Themselves	- Abiding by person-centred ideology, for example, "…We don't tell them [service users] what they want, they tell us. We work for them. They're the boss, you know? That's the mentality that I like to go into it." (Disability support worker Brian)
2. When "Speaking For" is Legislated: Quality Assurance Measures and Mandatory Reporting	- Workers are required to report sexual assault regardless of the survivor's wishes, for example, "According to the quality assurance measures, what the process is supposed to be is, you call the police right away…." (Disability support worker Stacy)
3. "Everyone has a Right to Know": Issues of Confidentiality	- Disability support workers are less strict about confidentiality, for example: "…if a [service user] broke her arm [and said], 'I don't want you to tell my mom,' that might be something that we would respect, but it's a fine line. At the end of the day, if someone's been sexually assaulted and they say, 'Don't tell anyone, keep it to yourself,' that's something I couldn't do, because…that would be against my role as [an employee] of this organization." (Disability support worker Brian) - Sexual assault support workers are more strict about confidentiality, for example: "When [a survivor who has a developmental disability is] seeking support…it's often difficult because the workers at the residence want to know, 'Why is she coming? Where is she going? What is she going to be talking about? Who is she going to be talking to?...it's not always as confidential as it should be, as she should have the right to be." (Sexual assault support worker Jenna

Table 1: Themes and Examples of Indicators (continued)

4. "Vulnerablization"	• Resisting vulnerablization by believing that service users are sexual and require access to sexual information, for example: " When you protect somebody from…sexual information, it's what we call the prison of protection, so when you have all these protective measures around somebody to keep them safe, really what you do is increase their vulnerability." (Disability support worker Stacy) • Reproducing vulnerablization by believing that service users are in need of protection, for example: "I think that *(pause)* I would probably be more protective of the [service user] than I might be of somebody who's of normal intelligence. I might be more protective and want to be there to be sure that they're able to be treated in a way that they would understand. I might have that kind of concern." (Disability support worker Diane)
5. Medicalization	• Resisting medicalization by rejecting medicalized labels, for example: "…We're very cautious not to label women….We want women to feel like [our organization] is a space, whether we're in [the organization itself or]…in the community, that they're not being labeled based on what society sees them as, but rather that we're here to give support around those specific issues." (Sexual assault support worker Jenna) • Reproducing medicalization by exclusively consulting medical model practitioners and not considering or knowing of alternatives, for example: "Some of the reflexes I would have is to ask the psychiatric departments at the hospital, or the [mental health hospital] or something, for support. Speak to the psychiatrist, [the dual diagnosis specialists at the mental health hospital]." (Disability support worker Eric)

Table 1: Themes and Examples of Indicators (continued)

Responses to Re-victimizing Constructions	
1. Disbelief	- Resisting disbelief by criticizing the criminal justice system's treatment of people who have developmental disabilities as incompetent witnesses, for example: "…I remember years ago, an assault case that went to court, and the woman with an intellectual disability was not considered a credible witness. *(pause)* This assault happened while she was in respite, and some of her answers to questions were such that how anyone could decide she was not a credible witness, I have no idea. So she was basically not believed…." (Disability support worker Liz) - Reproducing disbelief by questioning a survivor's story, for example: "…there's one individual who had indicated that [a family member] had probably assaulted her as a youngster….there was no way of corroborating from a third party." (Disability support worker Eric)
2. Victim Blaming and Responsibilization	- Resisting victim blaming and responsibilization by asserting that survivors did not cause the abuse, for example: "I think that *(pause)* some of the folks we support have had some horrendous experiences and didn't at the time recognize that…what the person did was wrong and that they were not bad people, they didn't ask for it, they didn't invite it." (Disability support worker Liz) - Reproducing victim blaming and responsibilization by stating that service users need to protect themselves, for example: "[The training sessions are] about trying to empower and to help the individuals to…empower each other to remain safe." (Disability support worker Eric)

Table 1: Themes and Examples of Indicators (continued)

3. Shifting the Focus: Avoidance	• Using euphemisms to shift attention from the violent nature of sexual assault, for example: "…apparently she said he'd taken advantage of her…" (Disability support worker Eric) • Focusing more on people who have a developmental disability as perpetrators of sexual assault, for example: "…traditionally I think that people with developmental disabilities, maybe because of secondary things like mental health or cognitive abilities, have been involved with different forms of assault or aggression…and I think, traditionally, we didn't look at those as criminal offences; they were just looked at as behaviour, whether the person knew right from wrong or not. That's now changed. As a result of that, a lot of the focus [of the organization's training] is on that." (Disability support worker Diane)
Negotiating Intersectional Identities 1. "…But We Don't Have Something Like That Right Now": Sexual Assault Support Workers Constructing Disability as a Less Important Identity	• Offering targeted programming for specific groups of marginalized women, but not for women who have a disability, for example: "…we don't have a specific program [for women who have a developmental disability] like we have with [other programs offered], where we're specifically saying we're going out and targeting that population." (Sexual assault support worker Karen) • Disability is not prioritized in training sessions when other experiences of oppression are, for example: "…we talk a lot about marginalized groups in our society and what that looks like in terms of supporting women through sexual assault." And: "…we have training on it [developmental disability], but it's not a main focus of our training." (Sexual assault support worker Karen)

Table 1: Themes and Examples of Indicators (continued)

2. "I Really Don't Think in Those Terms too Often": Lacking an Intersectional Analysis and Establishing the Primacy of Disability	• Acknowledging ableism but not sexism, homophobia, racism, classism, et cetera, for example: "…*(sighs)* I don't know, I really don't think in those terms [experiences of oppression other than disability] too often…" (Disability support worker Kevin) • De-gendering sexual assault policies, for example: "We felt that any sort of assault was assault and so we thought, in that context, it made sense to have how we would respond to any assault be…together." (Disability support worker Liz)

common subject throughout the interviews. Through their comments, workers supported this, yet the ideal was not always achieved.

Person-centred ideology has been increasingly prioritized within developmental disability-related organizations. This ideology acknowledges that generic care and support services created solely by support workers are insufficient, even inappropriate; instead, adults who have developmental disabilities should direct their support workers in creating a plan to attain the lifestyle they desire (Maes, 2003, p. 226). Person-centred services encourage workers, families, and advocates to speak with people who have developmental disabilities, allowing them to express their own needs for themselves rather than having non-disabled people speak for them. This ideology resists the infantilizing belief that people who have a developmental disability cannot make decisions or advocate for themselves. Stacy, a disability support worker, explained what person-centred ideology looks like within her organization:

> We're a very person-centred organization, which means that we work with people we support, and their families, to do a lot of individualized planning about what type of support they need, what kind of life do they want to have and how can we help them to get there…

Rather than having workers unilaterally determine what they think is best for service users, Stacy said that the service users are the ones who give direction. The workers and their families act with service users instead of for them. Disability support worker Brian also discussed the role of person-centred ideology in his work:

> …We don't tell them [service users] what they want, they tell us. We work for them. They're the boss, you know? That's the mentality that I like to go into it.

Brian's statement demonstrates a valuing and prioritizing of service users' opinions and feelings, as does Stacy's.

Disability worker Liz discussed the application of person-centred ideology to larger decision-making within her organization. She mentioned meetings that include staff and service users, during which they address proposed changes to organizational policies:

> We might do a process to help us all decide, 'What's our response to this? What do we think about this proposal…?' We do some of those processes as a gathering.

Rather than having all decision-making take place at the management level, service users' input is taken into account regarding the direction the organization will take. Taking person-centred ideology from the individual level to the organizational level indicates a commitment to resisting infantilization.

In each of these examples, the disability workers construct their service users as people who are just as entitled to make their own decisions as people who do not have a developmental disability. Rather than infantilizing service users by telling them what to do or shutting them out of the decision-making process, the workers resist infantilization by acknowledging their service users' right to direct their own lives.

Sexual assault support worker Jenna acknowledged that her organization has a role to play in addressing sexual violence against women who have developmental disabilities, but remarked that it is problematic to speak on behalf of other groups:

> We know that there's this gap in our community, and…we recognize our privilege and have to use our privilege in a way that is not *(pause)* speaking **for** *(emphasis)*, but finding ways to speak with those that…want to find resources to bring this issue to light.

Jenna took note of her abled privilege, stating that her organization has a responsibility to support women who have a developmental disability by speaking with them, rather than deciding what is best for them or claiming to represent them without their input.

Disability support workers and sexual assault support workers both mention instances where people outside of their organization infantilized survivors by speaking for them. While discussing challenges to accessing counsellors or psychologists, disability support worker Liz said:

> Finding someone who has expertise with folks with intellectual disabilities, and that speaks to the person, not to the person accompanying him or her [can be difficult].

Speaking to anyone other than the service user is infantilizing behaviour, which assumes that they cannot or should not speak for themselves; this is behaviour that Liz and the other disability support workers resist. However, in some instances, disability support workers may also participate in infantilization. Sexual assault support worker Karen said that disability support workers or family members "often" attempt to speak for service users who are accessing services at her organization:

> There's somebody [who has a developmental disability] coming in, and often someone else…will want to tell you the information before, so it's like, let her tell me herself.

Karen seems frustrated that the workers and family members feel the need to tell her why the service user is there, whereas a service user who does not have a developmental disability would typically be the one to share that information. Here, Karen resists infantilizing behaviour by asking the accompanying person to let the service user speak for herself.

When "Speaking For" is Legislated: Quality Assurance Measures and Mandatory Reporting

Though disability support workers resist speaking for survivors, there are times when workers are required by law to speak for instead of with. In 2011, all organizations "funded by the Ontario Ministry of Community and Social Services to provide services and supports to people with developmental disabilities" were required to comply with new quality assurance measures, as outlined in the *Services and Supports to Promote the Social Inclusion* *of Persons with Developmental Disabilities Act, 2008* (Ontario Ministry of Community and Social Services, 2015). According to the Ontario government, these regulations "help agencies…provide high quality services and supports and meet set standards" (Ontario Ministry of Community and Social Services, 2015). One aspect of the quality assurance measures that recurred in interviews is its mandatory reporting policy, wherein disability support workers are required to report any abuse that is witnessed or made known to them (Ontario Ministry of Community and Social Services, 2015). All three disability support organizations included in this project must comply with this legislation.

Mandatory reporting creates a conflict for service providers who resist speaking for survivors—the policy requires them to speak for the service user, regardless of what the service user wants. This concerns disability worker Stacy, who said:

> According to the quality assurance measures, what the process is supposed to be is, you call the police right away. Um, I understand why that is in place but it makes me a little uncomfortable. I think you really have to respect where that person is and what they want to do, and to be quite honest, people's experiences with the police are not always a positive thing. Um, so, *(hesitates, then laughs)*, yes, technically we would be expected to call the police.

Stacy also mentioned that some of the volunteers at her organization are uncomfortable with the policy:

> I think we've had some pushback around the call the police directly [policy], from our volunteers who say, 'Well, maybe I wouldn't want somebody to do that for me, how is that fair?' So there's been a little bit of pushback there.

Stacy and these volunteers recognize the ableism in a mandatory reporting policy that could negatively affect their service users, but would have no repercussions for them. Beyond Stacy's comments, though, no other disability workers directly criticized the mandatory reporting policy during the interviews.

Some workers did not appear to question the mandatory reporting policy at all. Brian accepted the policy, emphasizing the service user's involvement in the reporting process:

> They're in the conversation the whole time. It's not just us going behind their backs and doing everything. They need to be part of the conversation.

At face value, this comment may seem respectful; however, it is possibly an empty sentiment. Even if the service user is involved in the reporting process, if they did not want the assault to be reported in the first place, they were not truly "part of the conversation." Rather, the workers informed the service user what would happen, then proceeded to speak for them.

In some cases, there are contradictions between a worker's statements and the mandatory reporting policy. Liz described how a training session for service users addresses consent:

> Everybody in our organization has their own bedroom with a door on it, and you don't enter someone's bedroom without knocking and asking permission, and if someone says no, it's no. And it doesn't matter whether you're a [lower-level employee, administrator, or service user]….if I'm knocking on someone's door, it doesn't matter if it's me or if it's the [service provider] that just has been here a month. The person can say no and that will be honoured. That's a big piece of it. Consent is also talked about in those things because some of our [service users] do have relationships with other people that are of a sexual nature. When is it consent, and you always can say no. Again, that's huge, because people who are recipients of service often don't know that they have the authority to say no, and that that will be honoured, and that you will not have implications beyond here, you know. That's just so essential.

Though this particular part of the interview did not address mandatory reporting, Liz's insistence that "if someone says no, it's no" is in direct conflict with the mandatory reporting policy. This could be a source of confusion for service users, undermining their confidence in their words and assertions (Hingsburger, 1995, p. 81).

"Everyone has a Right to Know": Issues of Confidentiality

Mandatory reporting represents one way in which service users' confidentiality is breached. However, other complications regarding confidentiality came up in several interviews. Service users may face infantilizing beliefs and policies that serve to undermine their confidentiality.

Disability support workers Kevin, Diane and Brian each mention informing their superiors if a service user discloses that they have been sexually assaulted. Brian discussed the perceived importance of this action:

> Then it's following the process of informing *(pause, exhales audibly),* I'd have to…let my bosses know because they're the ones that know best what to do in terms of, *(pause)* yeah. I'm sure I would know how to handle it in the right way but just having that extra bit of support, and the thing is, that's the reason that makes us such an amazing team is that we share, we communicate, and we know of everything that's going on. Even if it's a quick e-mail, 'Hey, this has happened, I've done this, I've done that,' it's not necessarily asking for permission…it's informing and keeping them up to date throughout the process….With staff, it's a given. It's part of it. Like, one of our [service users] can't say, 'You can tell [one staff member] but you can't tell [another staff member].' Everyone has a right to know.

Brian said that he would not simply be asking for advice or permission in informing his superiors; he said that it is to "[keep] them up to date." His statement that all workers "know of everything that's going on" shows that there are limits to confidentiality within his organization. Furthermore, the fact that he thinks "everyone has a right to know" means that service users' confidentiality is only valued to a certain extent. He does not just say that his colleagues *should* be informed of the assault, but firmly states that they have a *right* to know.

Brian stated that when a service user joins his organization, they sign a "disclosure" allowing the organization to release personal information to certain people. He said that if someone disclosed assault to him, he would check who he could inform—typically, he would be informing a service user's parents. When asked what he would do if a service user asked him not to tell their parents, Brian said:

> There's certain things that we can say, like, if a [service user] broke her arm [and said], 'I don't want you to tell my mom,' that might be something that we would respect, but it's a fine line. At the end of the day, if someone's been sexually assaulted and they say, 'Don't tell anyone, keep it to yourself,' that's something I couldn't do, because…that would be against my role as [an employee] of this organization. And I wouldn't want to. Personally, I couldn't do that. It wouldn't be right.

While broken arms can be a result of assault, they can also be a result of an accident; sexual assault, however, is not an accident. Furthermore, the fact that a service user cannot withdraw their consent once the form has been signed is infantilizing and perhaps even dangerous. Brian did not account for the possibility that the service user may not have clearly understood the form at the time of signing, or that they may have been pressured to sign the form. He also does not know how the parents or caregivers would react when learning that the service user had been assaulted. Indeed, they may engage in re-victimizing behaviour that can be detrimental to the survivor's mental health, such as not believing or blaming the survivor, or isolating the survivor from their social networks (Hingsburger, 1995, pp. 15-16, 26; Ullman & Filipas, 2001a, p. 1029). Though Brian stated that his "number one [priority] is the safety and well-being of the [service user]," he did not acknowledge that the practice of informing colleagues and family members regardless of what the service user wants could jeopardize their safety and well-being.

Feminist support work organizations have strict confidentiality policies in order to protect the survivors who access their services. Both sexual assault support workers who were interviewed spoke about disability support workers who disregard service users' confidentiality. Karen mentioned that disability support workers and caregivers often pester sexual assault support workers for details on support sessions:

> We've had the experience—we've had this with a lot of, not just people with disabilities but with a lot of women who have [accessed our services], when it's a parent or somebody who's in kind of a parenting role, whether it's a teacher or someone like that, they often want to continue knowing what happened in the sessions. They want to know and we keep saying, 'Listen, it's a confidential space.' We have to really keep saying it over and over because we will keep getting calls from that person looking for- *(trails off, laughs hesitantly)* That's a challenge, because if you're a parent of somebody and they have a cognitive disability, you want to know, what can we be- *(trails off)* It's out of a concern for the person, but because that's not the way our services work we have to really [be firm]….In the case of someone wanting to know if that person's still coming for their sessions, we can't even let them know that.

Though it may be out of a concern for the service user, as Karen says, trying to find out what is happening in a support session infantilizes the service user by undermining their confidentiality. According to Robey, Beckley and Kirschner (2006), infantilizing attitudes are not necessarily "acted upon or expressed with some degree of intentionality" but "might be implicit and underlying" (p. 442). Even disability support workers may hold implicit infantilizing attitudes about disabled people (Robey, Beckley & Kirschner, 2006, p. 452).

Sexual assault support worker Jenna was critical of disability support workers, saying that their disregard for confidentiality makes it difficult for them to do their job:

> The workers are just so intrusive, and it makes it really difficult to support women [who have developmental disabilities]. And you **know** *(emphasis)* that they're constantly being surveillanced. Sometimes we're able to get around it, and sometimes it's a little more difficult because they're so micromanaged.

Jenna's comment is harsher than Karen's; though Karen finds it challenging to deal with workers and parents who fish for information, she gives them the benefit of the doubt by suggesting that their behaviour comes from a place of concern. Jenna is more definitive in her disapproval. She makes no attempt to excuse the disability support workers' actions, focusing instead on the implications of these actions for the service users. Elaborating on her comments about women who have developmental disabilities being watched and "micromanaged," Jenna provided more detail about disability support workers' attempts to undermine confidentiality:

> When [a survivor who has a developmental disability is] seeking support…it's often difficult because the workers at the residence want to know, 'Why is she coming? Where is she going? What is she going to be talking about? Who is she going to be talking to? How long are the sessions?'…We're able to craft it in very unique ways, at times, where we don't fully disclose [to the staff], but sometimes women themselves will disclose, because they feel like they have to, rather than they want to, because if they don't, then they won't be able to come. It's always this catch-22 where you know this woman is seeking support but at the same time, *(pause)* it's not always as confidential as it should be, as she should have the right to be.

Her description of disability support workers' persistence demonstrates their insistence on breaching confidentiality. This can be interpreted as a lack of respect for service users' confidentiality, and an underlying, infantilizing belief that service users do not require the same standard of services as people who do not have developmental disabilities.

Disability support worker Eric provided the opposite perspective, indicating his frustration in dealing with counsellors and other support workers. He described a situation in which a service user from his organization accessed support services from a disability-related community organization:

> I still really don't know what all it did because they [service providers] talk about confidentiality, so. *(laughs, then continues with emphasis)* It's like, okay, let's work together here, folks. Let's work together.

Eric evidently did not receive feedback about the service from the service user herself, indicating that she did not want to share this information. He felt as though he should be privy to the information and that the workers at this community organization should have shared it with him; or, as he phrased it, they should "work together." His laughter after mentioning confidentiality implies that he thinks confidentiality is less important than him getting information about service users' support sessions.

Disability support worker Liz gave some insight as to why workers try to get information from other support providers. Regarding interactions with psychologists and psychiatrists, she says:

> …typically, my experience has been, [psychologists and psychiatrists] listen and they certainly meet with the individual but they also, at some point, invite the folks [supporting the survivor in their daily life] to meet so that everybody can— *(stops herself)* Not that information is divulged that's not to be divulged, but so, as an organization or a team, we can learn how to support this person, and [find out] what makes sense. Found that to be very, very, actually quite extraordinary. And at times, it really felt like the psychologist or psychiatrist was part of the team, *(pause)* not somebody totally external who was just telling us what to do all the time, but was really listening to, okay, we did this and it might've been wonderful or it might've created more tensions. Was it our delivery? Was it just not a good idea at the time? What was it?

Liz's comments show that she and other workers are not sure how to work with survivors of sexual assault, and she seeks information from psychologists and psychiatrists because of that. Her comments indicate that she appreciates being able to work with these practitioners to address specific situations, rather than a having a distant exchange with "somebody totally external." Liz feels that having a service user's psychologist or psychiatrist as "part of the team" helps them to provide better support to the survivor in the context of everyday living. She does clarify that information "that's not to be divulged" is not shared, yet this still shows that these psychologists' or psychiatrists' confidentiality policies are not as strict as sexual assault support organizations' policies.

Liz and Eric both spoke about the desire to obtain information from mental health service providers. Eric wants them to "work together" and Liz values having them as "part of the team." However, regarding reaching out to organizations serving people who have developmental disabilities, sexual assault support worker Jenna said:

> We send e-mails, we try to connect, but *(pause, then speaking quietly)* sometimes we don't get a response back.

Jenna also stated that when they have done outreach to these types of organizations, they received mixed responses:

> Sometimes it's **not so great** *(emphasis)* and actually very difficult, because there's a complete denial of even needing this training.

Based on the conflicting accounts from disability support workers Liz and Eric and sexual assault support worker Jenna, there is a disconnect between these two types of organizations. Common ground must be found in order for them to move forward as partners.

"Vulnerablization"

Women who have a developmental disability are vulnerablized by infantilizing attitudes that construct them as asexual, childlike, and inherently vulnerable. As with the other ableist attitudes described above, disability support workers both resist and reproduce vulnerablizing narratives.

Disability support worker Stacy explicitly challenged the idea of people who have developmental disabilities as vulnerable, stating:

> People with disabilities aren't inherently vulnerable, it's not a characteristic of them. It's a construct of society.

Stacy pointed out that people who have developmental disabilities are seen as and made to be vulnerable by society, not because of who they are. She elaborated, stating that a person can be vulnerablized by behaviour that is intended to protect them:

> When you protect somebody from…sexual information, it's what we call the prison of protection, so when you have all these protective measures around somebody to keep them safe, really what you do is increase their vulnerability.

Indeed, sexuality educator Dave Hingsburger (1995) writes that parents and service providers create a "prison of protection" when they protect people who have a developmental disability from sexual information, decision making, relationships, and society. These four things form the "walls" of the prison and increase a person's vulnerability (Hingsburger, 1995, p. 13-16).

One of the "walls" of the prison of protection—protection from sexual information and sex education—was a main topic of discussion throughout the interviews. Disability service agencies in Ontario are required by the quality assurance measures to provide training on sexuality and abuse not only to employees and volunteers, but also to their service users. All of the disability support workers interviewed embraced this, stating that reactions to the training are generally positive and that other workers seem to understand the importance of the training. However, Stacy noted that some parents have expressed concern about the training for service users. She spoke about these tensions:

> I know we had, I guess, a little bit of concern sometimes from parents about the information we're providing. Not a huge amount of pushback but I think maybe they're still wanting to protect their kids from that type of information. So there's been a little bit of that.

Stacy acknowledged the parents' vulnerablization of their children, noting that they are still shielding their children from sexual information. Though she is tentative in criticizing the parents, she resists this vulnerablization by not giving in to their concerns. Instead, she communicates with the parents and her organization continues to provide this information to their service users. As she stated with finality regarding the provision of sex education at her organization, "This is important here and we do this."

Other disability support workers also had stories about parents vulnerablizing their children. In describing the service users at his organization, Eric said:

> …There's a wide range in terms of their ability….Some [disabilities] are more manifested than others. Some of them are, I would believe, perhaps more a result of, uh, *(searches for words)* a family or home environment which didn't provide or didn't have strong encouragement to, and I don't want to use the word "achieve," but to

> learn skills, based on whatever number of reasons…

Eric believes that some of his service users have been "dis-abled" more than others because they were given fewer opportunities to learn. While vulnerablization was not brought up during this part of the interview, his comments demonstrate that parents' actions affect what their child learns and, therefore, how vulnerable they may become. Brian linked vulnerablization to sexual assault, saying:

> I'm not trying to crap on parents or anything. *(laughs)* The majority of the parents we serve are great, but there are the few that just don't get it….Instead of being that support system, [they] can act as a barrier. And it's an incredible minority, what I'm talking about, but it's known to happen. Whether it happens in the case of sexual assault, I personally haven't experienced, but I can imagine that there would be some stuff there. *(long pause)* And…I'm not accusing the parents or anything but I think, were there barriers that parents were preventing their kids from accessing certain supports because they didn't think their son or daughter could do this, and that…resulted in them being more vulnerable?

Brian acknowledges that some parents make assumptions about their child's abilities, thereby creating barriers that have the potential to vulnerablize. In criticizing this practice, Brian resists vulnerablization.

Brian resists vulnerablization by acknowledging that some parents vulnerablize their children by making assumptions about how much their child is able to do and creating barriers.

In another statement, Eric resisted assumptions about his service users' ability to understand information about sexuality and abuse:

> You can have these [sex education and abuse prevention] programs, you have to modify them to the ability of people to understand, but you don't not do it because you feel they can't understand. You include people. You give people the opportunity to hear, and often it's the folks, the peers who can find other words that can make it more accessible to people that they share their homes with.

Eric's statement demonstrates a resistance to vulnerablizing attitudes. He acknowledged that it is important to be accessible and to modify programming to properly address the service users. Furthermore, he recognized his service users' ability to not only understand the material provided, but to assist their peers in learning. If disability support workers were to assume that the service users would be unable to understand this type of information, the service users would lose this learning opportunity which could possibly lead to increased vulnerability.

Protection from sex education is related to the construction of people who have a developmental disability as asexual. This myth was rejected by all of the sexual assault support workers and disability support workers interviewed. Sexual assault support worker Karen identified this myth as one of the root causes of vulnerablization:

> [People who have a developmental disability lack] access to people who are going to talk to you about what abuse is and…your own healthy sexuality and what that looks like. I think for a lot of kids growing up with disabilities, no one talks about that because [caregivers] don't see it as something that they're going to have to know about, which is completely wrong.

She resists a construction of service users as asexual by saying that it is "completely wrong" to assume that children who have developmental disabilities do not need to know about sexuality. She also emphasized the importance of having access to people who will teach about healthy sexuality, abuse, and the difference between the two. People who have developmental disabilities are often told that sexuality is bad or punished for expressions of healthy sexuality, causing difficulty in differentiating between healthy sexuality and abuse (Griffiths, 2007, p. 578; Hingsburger, 1995, pp. 6-8, 28-30). Disability support worker Stacy has witnessed this, describing service users before they participate in the sexuality training:

> [They] haven't learned about [sexuality] before, or heard about it before, or they've gotten really strange messages around abuse, sexuality, sexual violence; it's all

> jumbled up.

Both Stacy and Karen realize that failing to provide sex education is a serious problem. Karen said that there have been cases in which sexual assault support workers have had to provide a form of sex education in their sessions:

> I didn't have this experience but I know that some [workers] have been asked questions around sexuality and have actually had to teach women, like, do a sex ed kind of thing….A [service user might say], 'I don't know about this and I want to know about my own sexuality.'…Because if her only experiences has been a violent experience and no one else has ever taught her anything else, to talk about healthy sexuality you need to understand what that is, right?

Karen emphasized the importance of knowing about healthy sexuality in order to differentiate it from abuse.

Disability support worker Liz expressed a belief in maintaining an environment in which service users feel comfortable discussing sexuality. She told a story about a service user who wanted to talk about her relationship with her boyfriend:

> I think there's something about having close enough relationships with people that they can tell you the truth; [that] is really essential….One of the people in [our organization] will come to me around her boyfriend and [ask questions]….But it's about the relationship we have, that she can come in and say, 'I want to talk about sex.' Okay, let's talk about sex. And the time that she brought that up…about three months later I just said, 'Hey, how are things going between you and [her boyfriend],' and she said, 'Really well.' And I said, 'You know, if you ever want to talk about anything, you know my door is open, and if you want to talk to somebody else that's okay, too.' I didn't want her to feel like if she didn't talk to me, she couldn't talk to anybody.

By fostering an open and accepting atmosphere, Liz resists and challenges constructions of people who have a developmental disability as asexual. She demonstrates that she recognizes and respects her service users' sexuality through her encouraging attitude.

Despite the disability support workers' enthusiasm about providing sex education and abuse prevention programs to their service users, most of them said that their organizations did not provide such programming before the quality assurance measures came into effect in 2011. Stacy says that it is something her organization has "done for quite a while," but that it has not always been a policy.

Both of the sexual assault support workers had stories that contradicted the disability support workers' positive reactions to sex education and abuse prevention programming. Jenna spoke about the ways that disability support workers have reacted when her organization has done outreach training for service providers:

> It honestly varies. There's high turnover, too, right? So, it varies. Sometimes it's great [and they say], 'Thank you so much.' Sometimes it's **not so great** *(emphasis)* and actually very difficult, because there's a complete denial of even needing this training.

Jenna's story shows that attitudes toward information about sexuality and sexual assault are highly dependent on the attitudes of individual workers. She acknowledged that some disability support workers appreciate the training her organization provides; however, she mentions times when doing outreach was "very difficult" and that with some workers, there is a "complete denial" that they need to know about sexual assault. This contradicts the accounts of disability support workers interviewed for this research project.

The denial mentioned by Jenna may be caused by disability workers underestimating the prevalence of sexual assault. Even though all three women workers who were interviewed acknowledged the higher prevalence of sexual assault against women who have developmental disabilities, many male and female workers still seemed to underestimate how often it occurs. When asked if they had ever helped a service user access any type of sexual assault support service, some responses were:

> The opportunity has not come up, thankfully.…Fortunately, it's a very rare thing. It has not happened in my time here, that’s for sure. (Brian)

> I think we're lucky in that, since I've been here, there hasn't been a large number of individuals that we support who've been in that situation. (Diane)
>
> Since I've been [with this organization], there's really only been one situation that has happened, that I'm aware of. (Liz)

A number of issues are brought up in these quotes. First of all, Brian and Diane assume that because they have not heard of more cases of someone requiring support, there are no other service users who require these services. Brian goes so far as to assume that the need for sexual assault support services is "a very rare thing." Liz's comment is similar, mentioning that she has only dealt with one case. However, by stating that the case she dealt with is the only one that she is "aware of," she acknowledges the possibility of other service users having been assaulted. These three workers' accounts suggest that many service users do not disclose experiences of assault to their support workers, perhaps leading the workers to believe that assault is rare.

While Liz has only dealt with one instance of abuse that happened while she was with the organization, she told a chilling story about disclosures of past abuse of service users, especially those who used to live in institutions:

> I would say **every** *(emphasis)* person that I have talked to that has come from an institution at some point in their life has experienced assault, sexual assault being one of the assaults….I think about women in particular who have disclosed assault, and I would say there are very few who have **not** *(emphasis)* disclosed it over the years, since I've been here, to me. And it's usually been old, old stuff.

Liz's story demonstrates that she knows that many of her service users are survivors; however, she states that most of the disclosures are of historical assaults.

Further assumptions that assault is uncommon are evident in disability support worker Stacy's account of reactions to sexual assault statistics in a volunteer training session:

> I think [volunteers] are quite shocked to hear how many people [who have a developmental disability] experience abuse and sexual violence.

The volunteers' shock indicates their lack of awareness of the prevalence of sexual assault against women who have a developmental disability. Even if Stacy's organization addresses the statistics in their training, if workers believe that the sexual assault of women who have a developmental disability is uncommon, or that it is less frequent now than it was in the days of institutions, they may be less likely to believe that training regarding sexual assault is necessary.

Sexual assault support worker Karen raised another concern: that disability support workers do not know how to deal with the issue of sexual assault, particularly disclosures of assault. She drew from what survivors have told her:

> Or even if they [disability support workers or caregivers] do believe it should be taken seriously, do they even know how to deal with it?...I've heard a lot of women…say, 'It was dealt with, maybe not in the greatest way ever,' but then afterwards [the workers say], 'Okay, it's done. We're gonna move on now.' You have people around you who control those aspects of your life, and [the survivor says], 'No, I haven't healed from this.' People just want to go on and not talk about it anymore; it could be your family members who don't want to think about it, or your staff who don't want to think about it. I think there's a lot of trying to sweep it under the rug and [workers saying], 'Okay, we've called the police, we've made reports, now let's just live our life from here.' So, I think there's the experience of sexual assault and then the experience of how people deal with it.

Karen differentiated between the experience of being assaulted, and the experience of how others handle a disclosure. She points out that disability support workers have power over their service users, and states that workers might use this power to disregard a survivor's healing process or "sweep it under the rug." Karen acknowledged that people, whether they are disability support workers or family members, often do not want to speak about sexual assault.

Despite the workers' acknowledgement that vulnerablization is, in part, caused by protection, some disability workers still believe that their service users are in need of protection. Disability workers Diane and Eric both made statements to this effect. When Diane was asked about potential obstacles when accessing sexual assault support services, she responded:

> I think that *(pause)* I would probably be more protective of the [service user] than I might be of somebody who's of normal intelligence. I might be more protective and want to be there to be sure that they're able to be treated in a way that they would understand. I might have that kind of concern.

Diane's "concern" comes from a good place, much like the concern that some disability support workers exhibit when wanting to learn what their service users are doing in support sessions. She pointed out that she wants to advocate for her service users.

Medicalization

The feminist support work model exists as an alternative to the medical model, and the sexual assault support workers who were interviewed resist medicalization. The disability support workers' relationship with the medical model was more complicated; they reinforced medicalization, often unquestioningly, yet raised several concerns regarding the medical model. However, with only one exception, they did not present or acknowledge alternatives to this model.

Sexual assault support worker Jenna resists "labelling" women who use the services at her organization:

> …We're very cautious not to label women….We want women to feel like [our organization] is a space, whether we're in [the organization itself or]…in the community, that they're not being labeled based on what society sees them as, but rather that we're here to give support around those specific issues.

Jenna referred to any type of label that could be applied to a person, including medicalized labels or diagnoses. Her organization aims to welcome service users by not immediately relegating them to a socially constructed identity. Jenna went on to discuss how medicalized labels applied to service users can be detrimental:

> [Some of our service users] in mainstream society would be labelled, like, legitimately as 'crazy' and 'they need to be locked up and you need to put them away because they're not **okay**' *(critical tone)*, right? They've been turned away so many times from other organizations because they've been seen as manipulative. So we ask [potential support workers]…'Are you willing to be able…to think out of the systemic box that we've been taught to think in? Are you willing to do that?'

Jenna knows that some of her service users have been turned away from other organizations because of the way they have been labelled, as well as the ableism tied to these labels. By resisting medicalized labels, her organization serves people who may otherwise be unable to access support services. Disability support worker Stacy confirmed Jenna's statement that diagnoses and the ableism associated with them can be a barrier:

> We support…a lot of people with what's known as a dual diagnosis, so people who have an intellectual disability and also some mental health, either mental health issue, mental health concern, known in system speak as challenging behaviour, things like that. So we tend to support a lot of people who may have traditionally fallen through the cracks.

Stacy noted that people who have medicalized labels imposed on them may be unable to access services; they "fall through the cracks."

Disability support worker Kevin resists medicalization by using labels as tools, not descriptors:

> They're [service users] all individuals, they're all unique persons with their own special *(pause)* needs, requirements, in life. So, I tend to look at each individual as an individual, and use any sort of medical terminology, medical diagnosis as a tool for working with professionals for medication dispensing, for personality dis- *(stops himself)* traits, and such.

Kevin hesitated to use medicalized labels in reference to his service users. He stopped himself from using such labels here, as well as throughout his interview. The fact that he is required to use labels or diagnoses as tools for dealing with other service providers, and that he must consciously stop himself from using these terms, demonstrates the prevalence of medicalization. However, by stating that he only uses these terms when necessary in his job, he seems to demonstrate resistance to them.

During the interview, sexual assault support worker Karen acknowledged that: "women with disabilities can be really wrapped up in the medical system." She went on to speak about her experiences supporting women who have a developmental disability to access and navigate medicalized services:

> [Service users have asked,] 'I want you to come to this doctor's appointment and take notes, or explain to me what this doctor is telling me, because it's scaring me.'…I don't think I've ever had to explain anything to anybody; it's more just having somebody there to be a second person so that they can say, 'This is what I understood; is that what you understand, too?'

However, Karen interpreted doctors' reactions to her presence at service users' appointments as highly negative:

> Doctors don't like that **at all** *(strong emphasis, then laughter)*….I've been at appointments and I've also just sat outside appointments, but, I don't know, on a certain level I think, when they see that there's somebody else there who's concerned about what they're doing, like psychiatrists and stuff….I don't know if a [service user] would say this but…I feel like it…made them [the medical practitioner] way more accountable if they saw there was somebody there who was obviously talking to [the service user] afterward about what they said to her. 'Cause, I don't know, suddenly things would change a lot. *(laughs)*

Karen emphasized that medical professionals seem to strongly dislike it when she accompanies a patient who has a developmental disability to an appointment. She believes that her presence as a "concerned" observer increases the practitioner's accountability. This suggests that the practitioner may have been treating the service user in an infantilizing or otherwise disrespectful manner when she attended an appointment by herself.

All of the disability support workers reinforced the medicalization of sexual assault in their interviews. When asked how they would respond to a disclosure of sexual assault, hospitals were a main focus:

> Oh, the first thing, first things first is hospital….Get checked out, health wise, number one. That's got to be the first point of contact, getting to that stuff. (Brian)
>
> If it [happened] last night, I'd have to talk to her about, we need to go to the police, we need to go to the hospital… (Liz)
>
> I mean, a hospital is a hospital, so if somebody's sexually assaulted, I think people just know that you have to do that [go to the hospital]. (Diane)

All three workers used absolutes. This suggests that they do not question the medical model's primacy, and in doing so may be further reinforcing the medicalization of sexual assault and of survivors.

During the interviews, when mental health was the subject of conversation, disability support workers largely defaulted to discussing psychology and psychiatry. When asked about responses to sexual assault, these workers brought up medicalized services and did not mention non-medicalized services. An example of this is found in disability support worker Eric's response to what he thinks of when he hears of "sexual assault support services:"

> Some of the reflexes I would have is to ask the psychiatric departments at the hospital, or the [mental health hospital] or something, for support. Speak to the psychiatrist, [the dual diagnosis specialists at the mental health hospital].

By stating that it would be a "reflex" to consult psychiatrists and services at a mental health hospital, Eric shows how ingrained is the medicalized approach to sexual assault.

Through their adherence to medicalization, the disability support workers reinforce the pathologizing of survivors and thus the need for a medical response. However, disability support worker Kevin made a very affirming statement that resists the tendency to pathologize:

> They're reacting emotionally to an emotional situation. *(matter-of-fact tone)* They're going through something very- *(trails off)* I can only imagine, so I have to be aware of that.

This attitude is supportive of survivors, respecting their emotions and healing processes and recognizing survivors will have diverse reactions to sexual assault that he cannot know. By stating that sexual assault is an emotional situation to which people may react emotionally, rather than categorizing it using the medicalized terminology of "disorders," Kevin validates survivors' responses.

There were instances during the interviews in which disability support workers showed a reluctance to allow service users to make their own medical decisions. This was not only an example of medicalized beliefs positioning medical care as essential, but also of infantilization. Disability worker Brian spoke about care:

> And obviously, the medical, emergency, if [service users] say, "I don't want help," if it's the [service user's] safety then it's something I have to insist on. At the end of the day I've got a duty of care….And the sooner, the first 24 hours is crucial, right? Knowing that it's a time thing for DNA or anything like that [gathering evidence for a police report]. Emotionally, as well, breaking down, getting on it straight away for the [service user's] physical and emotional well-being. It's crucial. I think you can't just sit on it.

Brian believes that his service users' safety and well-being would be jeopardized if they did not seek medical attention quickly after a sexual assault. He is correct in assuming that evidence collection must happen as soon as possible, however, most survivors do not report sexual assault to the police (Beres, Crow & Gotell, 2009, p. 144). While there are other benefits to presenting to the emergency department, such as receiving medication to prevent sexually transmitted infections and unwanted pregnancy, survivors are often re-victimized when seeking medical treatment. Brian's idea of well-being does not account for the possibility of re-victimization. Furthermore, Brian discussed the "barrier" presented by service users who do not want to attend medical appointments:

> Compliance of the [service user] is a big thing, their willingness to participate and be open and want to go to the appointment.

That he mentioned the service users' willingness to "comply" portrays a belief that attending medical appointments is not a matter of choice, but a necessity.

Despite the overwhelming belief that medical care is required for a sexual assault, Liz told a story about one of her service users who had refused care:

> We support one person right now who's really an angry individual. Again, that's layman's jargon, it may not mean anything….He refuses to see anyone [psychologist or psychiatrist]. And we live with that, too.

Liz seems to think that this service user would benefit from seeing a psychologist or psychiatrist, but rather than imposing this belief on him, she has accepted his decision that he does not want to seek assistance.

Stacy, Liz and Eric were concerned that some medical model practitioners have little experience with or knowledge about people who have a developmental disability. Stacy has encountered practitioners who do not think that they should have to serve people who have a developmental disability:

> Sometimes there tends to be the opinion or attitude or mentality that if somebody has a disability, then they need to be taken care of by disability[-specific] services. So [they say], "That person has a disability, well, that's your problem, you deal with those people." That happens in the health care system and in mental health care—it happens a lot, where there's pushback to say, "You work with those people, not me."

These service providers are attempting to segregate people who have a developmental disability, relegating them to disability-specific services; they seem to view people who have a developmental disability as "problems" to be "dealt with" by someone else. Stacy pointed out that such exclusionary attitudes create barriers to services. Regarding these barriers, Eric discussed a lack of practitioners who know how to work with people who have a developmental disability:

> My brain goes to specialized services as opposed to just generalized services, with an ability to respond to special needs. I prefer the latter, but then that means you have to have [service providers who know how to work with people who have a developmental disability] in place. That is very expensive, keeping people available. Money's a big issue.

Eric is sceptical that most generalized services would have service providers who have the ability to effectively work with people who have a developmental disability. Because of this, he says that even though he prefers generalized services, he tends to think of specialized services first.

Liz was critical of practitioners who do not know how to work with people who have a developmental disability, calling them out on their ableist behaviour:

> Finding someone who has expertise with folks with intellectual disabilities, and that speaks to the person, not to the person accompanying him or her [can be difficult].

Liz's criticism demonstrates that just because a practitioner is a "professional," this does not mean that they will be respectful or even know how to work with people who have developmental disabilities. Stacy criticized some practitioners' closed-mindedness regarding the efficacy of counselling for people who have a developmental disability:

> Not necessarily related to sexual assault but we've also heard from different organizations—I'm not sure, I can't remember which one it is directly—who really think that people with intellectual disabilities don't benefit from counselling…they shut the door before the person is even there. That's happened to a number of people we support; [the practitioners say that counselling] won't help you, or, you don't have the cognitive ability to benefit, and that's not true. That's a barrier.

Both Stacy and Liz construct their service users as worthy of any service available to the general population, acknowledging other service providers' ableist attitudes and the barriers that these attitudes create.

Kevin, Eric, Stacy and Liz all expressed concern over the cost of medicalized services. Liz refers to the fees that some practitioners charge as "extraordinary." These four workers acknowledge that their service users generally have a limited income, making services that charge a fee inaccessible. These workers do not acknowledge that services offered through the feminist support work model are free of charge. Sexual assault support worker Karen also acknowledged financial barriers for women survivors who have a developmental disability:

> [In training we discuss] the fact that our services are free and what that means, because there's people on disability [Ontario Disability Support Program, long-term disability leave, etc.] who…don't have a lot of cash to use for services…

Karen's recognition that accessibility also includes financial access acknowledges the lived experiences of many women who have a developmental disability.

Eric, Stacy and Liz were also critical of the wait times typical of medical model services. Liz stated that it is unacceptable to leave survivors on the long waiting lists that are common within the medical model:

> I think in any kind of situation of abuse, timeliness is really essential. You can't say, 'Oh, well, we'll see you in 18 months.'

In addition to wait times, Stacy and Kevin perceived a lack of long-term supports for survivors of sexual assault who have a developmental disability. Diane brought it to her own organization's level, speculating that their training does not adequately address what to do for a survivor's mental health in the long term.

Throughout the interviews, it seemed that organizational links between the disability-related services and the sexual assault support agency were not strong. The disability support workers interviewed have little knowledge of the feminist support work model. They may be aware that these services exist and have a vague idea about the types of services they provide, but most did not have any further knowledge or experience in dealing with these services. Furthermore, when asked about "sexual assault support services," most of the disability workers only mentioned services available from psychologists and psychiatrists, and only after probing did they mention the feminist support work model. Many of the disability support workers said that they choose to refer service users to services that "match" their needs or personality, however, they are doing so with little or no knowledge of the feminist support work model and as a result they may be likely to overlook some services that could be suited for their service users.

The disability workers' lack of knowledge about the feminist support work model contrasts with their familiarity with the medical model. Often, the workers had firsthand experience dealing with service users' psychologists and psychiatrists. Some of the workers had positive things to say about these experiences, though all of the workers were critical of at least some aspects of medical model services.

Though most of the disability support workers interviewed knew little about the feminist support work model, Stacy was an exception. Her organization worked with a sexual assault support organization in the city in the past. She spoke positively about this experience:

> We did some work directly with [a local feminist support work organization] and they seemed to be **really good** *(emphasis)*. Again, I can't speak as a service user, so there's always that. But they seem to really want to be very welcoming and inclusive

> and looking for ways to make sure all women felt comfortable accessing them, which I think is great. So they were going out of their way to make that happen.

Stacy's enthusiasm about her organization's partnership with a feminist support work organization demonstrates that these types of organizations may benefit from one another's knowledge and experience.

Responses to Re-victimizing Constructions

This theme addresses interviewees' responses to re-victimizing constructions, dealing specifically with disbelief, victim blaming and responsibilization, and workers avoiding the subject of sexual assault.

Disbelief

The sexual assault support workers and, for the most part, the disability workers interviewed rejected others' disbelief of survivors of sexual assault. The interviewees primarily addressed this in regard to the criminal justice system's treatment of survivors, particularly survivors who have a developmental disability.

Many interviewees addressed the criminal justice system's tendency to not believe survivors of sexual assault. The mandatory reporting policy outlined in the quality assurance measures states that the police must be contacted following allegations of sexual assault. Disability support worker Stacy criticized how this policy was implemented:

> I don't know if the Ministry [of Community and Social Services] really consulted with the police, because there…seems to be a disconnect. So the police are saying, 'Why are you calling me? Why are you calling us with this?'

Similarly, sexual assault support worker Karen said that survivors have told her that police often do not "…believe that there is something to be taken seriously." Disability support worker Kevin echoed this statement. Though he believes that people who have a developmental disability should be "offered the choice" to pursue criminal charges, he lacks faith in the criminal justice system:

> I have my biases about the police, the **legal system** *(critical tone)* and these cases, that's all.

Kevin's "biases" are based on situations that he has observed. According to him, the police often claim that a case is not "worthy of pursuit," demonstrating their disbelief immediately. While this is a common experience for survivors of sexual assault in general, in the experience of these interviewees it is compounded for survivors who have a developmental disability. Sexual assault support worker Jenna and disability support workers Kevin and Liz noted that the criminal justice system often does not view people who have a developmental disability as "competent" witnesses, despite evidence to the contrary (Valenti-Hein & Schwartz, 1993). Due to this, Jenna was sceptical of the police's willingness to believe survivors who have a developmental disability:

> …Say, if a woman [who has a developmental disability] were to go to the police, the likelihood of being believed? I don't know [how likely that is]. Having the **capacity** *(critical tone)* to know what was wrong, would that be a judgment by police?

Jenna's critical tone demonstrates her resistance of the myth that women who have a developmental disability are incompetent witnesses. Furthermore, Liz detailed a case that she was aware of before she worked at her current organization:

> …I remember years ago, an assault case that went to court, and the woman with an intellectual disability was not considered a credible witness. *(pause)* This assault happened while she was in respite, and some of her answers to questions were such that how anyone could decide she was not a credible witness, I have no idea. So she was basically not believed. The fellow [perpetrator] was canned. So, it was mixed messages all over the place. It was just horrendous.

Liz resists the notion that a developmental disability precludes a person's ability to provide accurate and credible testimony. Lastly, disability support worker Stacy noted her own discomfort with mandatory reporting policies because of the criminal justice system's treatment of survivors:

> …[Survivors] don't always want to report [an assault to police], often with good reason because they just end up re-victimized in the criminal justice system. *(pause)* So I would be perhaps a little uncomfortable to charge to that, knowing what that might do to the person.

However, the implementation of the quality assurance measures means that she has no choice but to comply with the law.

Two disability support workers recognized the impact of service providers, particularly counsellors and clinicians, not believing survivors. Eric said that it is important for counsellors, psychologists and psychiatrists to be objective and to provide a "trusting environment" so that a survivor "can truly get their story out." In the absence of such an environment, a survivor may believe that their concerns are being dismissed and that the service provider does not believe them. Brian also emphasized the need for a supportive atmosphere:

> …it's important [for a service provider] to have empathy, because a lot of the [service users]…feel like they're not being heard, 'No one cares about me,' [or] 'They don't get me.' That's a big part of it, too.

Without specifically mentioning re-victimization, both Brian and Eric acknowledged the potential harm of re-victimization and the need to avoid it.

Though the disability support workers rejected the attitude that survivors who have a developmental disability cannot be believed because of their disability, there were some instances in which a worker made statements insinuating disbelief. Disability support worker Eric made statements throughout his interview about seeking the "truth" about or "proof" of sexual assault, and "corroborating" a survivor's story. This exemplifies the rape myth that women lie about sexual assault and cannot be believed without corroboration (Campbell &

Raja, 1999, p. 262). Re-victimizing statements such as these should be considered in light of sexual assault support worker Karen's story about survivors who have told her that they were not "believed" by the staff at their group home.

Lastly, disability support worker Eric did not acknowledge how disbelief might affect a survivor who has a developmental disability when attempting to access support services. When asked about barriers to access, he said:

> …A vulnerable person who is accusing somebody of assault might even get more sympathy, a more quick response, because they're vulnerable.

Here, Eric failed to account for the widespread disbelief that sexual assault survivors encounter, and particularly those who have developmental disabilities. He also appears to assume from this comment that survivors would be able to access the appropriate services in the first place.

Victim Blaming and Responsibilization

When discussing vulnerablization, the disability support workers addressed the need for people who have a developmental disability to learn about healthy sexuality and abuse prevention. While these education initiatives are important, the strong focus on learning to protect themselves shifts the focus onto victims and potential victims of assault, rather than placing it on abusers. This is a type of "responsibilization"—that is, holding women responsible for preventing male sexual violence. For example, disability support worker Eric described the training sessions mandated by the quality assurance measures:

> [The training sessions are] about trying to empower and to help the individuals to…empower each other to remain safe.

This focus on "empowerment" and "remaining safe" puts the onus on women to protect themselves, shifting the focus onto potential victims instead of perpetrators.

During the interviews, there were several instances in which disability support workers described situations that were a result of vulnerablization using victim blaming language. Eric linked service users' vulnerability to their requirements for personal care and a lack of assertiveness:

> Some people have very high needs in terms of personal care. Some are quite vulnerable. Others are much more independent and very clear as to where their boundaries are and their limits are.

Categorizing a service user's vulnerability based on whether they are "very clear" about their "boundaries and limits" may have the effect of blaming those who are not clear about their boundaries, or who do not communicate these boundaries and limits in normative ways. This type of blame is not limited to women who have a developmental disability; the andro-centric bias in social and legal institutions supports a belief that even when women clearly indicate non-consent, they meant to say yes despite having said no (Kimmel, 2008a, pp. 219-220; Perry, 2008, p. 194). Disability support worker Diane also discussed this:

> For some women who have been in a residential setting for a long time, their care [has] been having many [service providers] who maybe will be supporting them, with baths, with other personal care. So, they may not have the same inhibitions as other people. As well as recognizing when that line is crossed. But that's sometimes. I'm not saying that's for all of the [service users] but I think for some people, knowing when a hug is not appropriate, is inappropriate [is unclear]. And for others, I think it's quite clear.

Like Eric, Diane focused on whether a service user is "clear" about their boundaries. The statements impart at least some blame for any assault on a service user who was not "clear;" implying that they would not be assaulted if they plainly and confidently stated their disapproval.

In some of his comments, disability support worker Brian failed to problematize the concept of vulnerability, leading to responsibilizing statements. This is particularly evident in an example he gave about students being denied accommodations:

> Something that is quite common is that a lot of [service users] have a hard time saying no, especially to people in authority positions. Their teachers [might say], "We're just going to get you to do the test with the rest of the class," even though you have the right to do it on your own. Even though [the service user knows] that they prefer to do it in a one-on-one setting, they'd be like, "Yeah, sure, that's okay," because it's the desire to please. The desire to please, the anxiety of, "I don't want to upset anyone, I don't want them to hate me, I don't want to be a bad person." It's unfortunate that the people who are in these positions of power have this over this vulnerable population.

Rather than stating that the "people who are in these positions of power" should not abuse this power, Brian focused on the fact that some service users "have a hard time saying no." In the interview, he did not directly address the ableist power structures that cause some people who have a developmental disability to experience self-doubt, anxiety, or fear when challenged by people in positions of authority. Because this was not problematized, his statements about "having a hard time saying no" take on a tone of victim blaming. Though his example deals with a test at school and not an assault, the power dynamics at play are still relevant. Furthermore, Brian's choice of language in describing abuses of power downplays the authority figures' ableism. He used the word "unfortunate," implying that these circumstances are merely unlucky, rather than denouncing the oppressive acts with a stronger, more definitive word such as "unacceptable" or "inexcusable."

A more direct example of victim blaming occurred during Eric's interview. While telling a story about a service user who may have been sexually assaulted, he said:

> It wasn't her first experience; she has had other experiences where she's left herself somewhat vulnerable.

The language of a woman "leaving herself vulnerable" places the responsibility for assault directly on her and her actions, rather than on the perpetrator.

Despite the—perhaps inadvertent—victim blaming present in the interviews, the disability support workers seemed to identify victim blaming as a societal problem. Disability support worker Kevin criticized the criminal justice system for assuming that people who have a developmental disability who have been sexually assaulted "brought it on." He also observed that survivors often experience "self-blame, wrongly placed," adding that his role is to "stop the questioning [of the survivor]." Disability support worker Liz also witnessed self-blame:

> I think that *(pause)* some of the folks we support have had some horrendous experiences and didn't at the time recognize that…what the person did was wrong and that they were not bad people, they didn't ask for it, they didn't invite it.

Liz and Kevin each reject victim blaming and the circumstances that cause it.

Likewise, many of the workers interviewed stated that perpetrators are to blame for sexual assault, not survivors—even disability support workers who had made victim blaming statements. The sexual assault support workers did not focus on the "vulnerability" of women who have a developmental disability; instead, they focused on the power wielded by perpetrators. They each concentrated on the fact that abusers are often caregivers who, as Karen said, have "a lot of control [over] and a lot of access to" their victim. Karen also said that perpetrators may "target" women who have a developmental disability because they know that the survivor will likely not be "believed or understood." Disability support worker Liz noted that sexual assault "is all about power," a statement that was echoed by Stacy and Brian. In direct opposition to victim blaming narratives, Liz and Eric both discussed putting the onus on workers to prevent violence, as opposed to the service user. Liz stated that it is "**really** essential" (her emphasis) for workers to obtain consent for everything they do, and Eric put the responsibility on workers to not "step over boundaries."

Shifting the Focus: Avoidance

Though the disability support workers largely acknowledge that sexual assault is a problem, they employ some methods of ignoring the problem or shifting the focus from it. This was mainly exemplified by the use of euphemisms to describe sexual assault, and by shifting the focus away from survivors and onto people who have developmental disabilities as perpetrators of assault.

The continual use of euphemisms for assault, such as "take advantage of," throughout the disability workers' interviews shifted attention from the violent nature of sexual assault, even serving to de-emphasize it. Using euphemisms or passive terminology may "imply consent or romance" and "allow the perpetrators of this violence to remain invisible and unaccountable" (Washington Coalition of Sexual Assault Programs, 2012). This terminology also implies an inherent vulnerability.

When discussing issues surrounding sexual assault and women who have a developmental disability, the focus in the disability workers' interviews sometimes shifted from survivors to people who have a developmental disability as perpetrators of sexual assault. This was also encountered frequently in the literature review process; it was at least as easy, or even easier, to find academic articles researching perpetrators of sexual assault who have a developmental disability than to find research about survivors. Along these lines, disability support worker Diane said that "a lot of the focus" of her organization's abuse training is on how to work with service users who are perpetrators of physical or sexual assault. Disability support worker Eric discussed how this is manifested in the availability of legal and other services for people who have a developmental disability:

> In terms of the legal point of view, I think there's more services for individuals who are accused of sexual assault, even within developmental services, I could be wrong, than [for] those who are being attacked. That's my sense. It's not cynicism, it's just my awareness. [A mental health organization] has a…program that will provide services…for folks with developmental disabilities who have been accused of assault. But I never quite hear the other side, of what services are provided for the other folks, the folks who are the victims.

Diane's example was limited to her own organization, but Eric's perception of existing services demonstrates a systemic shift of focus toward people who have developmental disabilities as perpetrators. Furthermore, when asked about what the volunteer training at his organization covers, disability support worker Brian twice referred to people who have developmental disabilities as perpetrators of sexual assault. In one of these statements, he said that "a lot of the new volunteers" have asked what they should do if a service user "puts their hands on [them]." This suggests that the perception of people who have developmental disabilities as perpetrators of assault is not limited to disability-related communities, but is widespread. These are examples of the socially constructed myth of people who have developmental disabilities as hypersexual, "perverted," or "deviant" (Richards et al., 2009, p. 185), as well as the myth that constructs perpetrators of sexual assault as perverted or deviant (Kimmel, 2008b, p. 330). Furthermore, this focus detracts from survivors of sexual assault.

Negotiating Intersectional Identities

Many of the workers interviewed for this research project demonstrated at least some acknowledgement of their service users' intersectional identities. However, this was not always reflected in their constructions of their service users or in the way their organizations operate. In particular, the sexual assault support workers tended to construct disability as less important than other identities, while the disability support workers constructed disability as more important than other identities. The sexual assault support workers were reflexive, acknowledging many of their own potential shortcomings, while the disability support workers largely failed to acknowledge the impact of service users' other experiences of oppression. This theme encompasses the sexual assault support workers' construction of disability as a less important identity, and the disability support workers' lack of an intersectional analysis, alongside their privileging of disability as the most important identity.

"...But We Don't Have Something Like That Right Now": Sexual Assault Support Workers Constructing Disability as a Less Important Identity

The sexual assault support workers interviewed acknowledged disability as an important identity to include in their work and reflected upon the accessibility of their organization. When asked whether most of the workers at her organization would be open to supporting a woman who has a developmental disability, Jenna said:

> You have to be. It's not an option. Because that's almost like saying, 'Are you willing to support a person of colour?' You, no. *(laughs)* From the lens we're coming from, you are willing to. Absolutely.

By equating ableism with racism, Jenna demonstrates that her organization's policy is inclusive of women who have a developmental disability. However, throughout the interviews, the sexual assault support workers still tended to prioritize other experiences of oppression, constructing disability as less important than other identities. This indicates that there is a gap between their organization's ideology and their practice.

In their interviews, the sexual assault support workers detailed the programs offered by their organization, many of which are targeted toward specific groups of marginalized women. However, Karen stated that while some of their existing outreach overlaps with disability, including developmental disability, they:

> …don't have a specific program [for women who have a developmental disability] like we have with [other programs offered], where we're specifically saying we're going out and targeting that population.

When asked why they do not offer targeted programming or specifically reach out to disability communities, the sexual assault support workers cited insufficient resources. Karen explained her perspective:

> I would love to see a program specifically for people with a disability…I think we're taking on more and more, but we don't have something like that right now. Really, it's a resource issue. I think we would if we had the resources for it, but right now, we have **so** *(emphasis)* many women [accessing existing services] to begin with, that we've often talked about outreaching to different groups, but…we have to make sure we're not going to outreach to a group and then not have the services to back it up, right? If we go out to a group and we talk about it and there's people with disabilities and we say, 'Yes, you can use our services.' That's great, except it's up to us now to make sure that we're not going to leave people on waiting lists and we're not going to have them call crisis lines that are busy…it's just not responsible.

Though her organization does not specifically target disabled women, while targeting other women based on their identities, Karen pointed out that disabled women are welcome at their organization.

Karen's above statement addressing waiting lists and insufficient resources is related to a concern raised by disability support worker Liz, who focused on the number of her service users who have survived assault and sexual assault. She was sceptical of the availability of services for survivors:

> …I would say there are very few [women service users] who have **not** *(emphasis)* disclosed it over the years, since I've been here, to me. It's usually been old, old stuff….And at this point, those folks don't want to come forward. But my hunch is, if they all decided to come forward, it [the amount of services] wouldn't be enough. It wouldn't be.

This shows that both types of workers have concerns about the amount of services available.

The training provided at the sexual assault support workers' organization addresses how their service users, including different groups of marginalized women, "experience violence." Jenna explained the importance of intersectionality to her organization's training:

> …We don't want to take these individual [types of oppression] and just see them as silos [gestures indicating separate, spaced towers]…[we] try to provide a more intersectional, holistic approach of how our service users experience violence, and also that women are not just, you know, a black woman, but it could be a black woman who may be living in poverty, who may be on ODSP [Ontario Disability Support Program] and may be queer. So, being able to ensure that the way that the women's lives intersect really influence the way that they experience and are able to access support.

Karen also states that discussions around disability are "woven into the rest of the training," indicating a further commitment to intersectionality. Despite these statements about the content of the training, however, developmental disability is not discussed in great detail. Karen said that they talk about developmental disability "a little bit" in training, but that "it's not a main focus of our training."

The sexual assault support workers said that there is additional, ongoing training, but that these training sessions are "usually not mandatory" and are conducted on topics of interest. Karen explained how these sessions are decided upon:

> [Additional training] tends to come up when people say…'We want to learn more about this,' or if somebody sends out something on e-mail that says, 'This is really interesting, I want everybody to learn.' It's more like that. The only time [an additional training session] is mandatory is if there's something happening that we see, like, we **reeeeeally** *(emphasis)* need to know about this, and then we might make it mandatory.

Because additional training topics are chosen by the workers themselves, and are not mandatory unless the topic is of great importance, there is no guarantee that workers would learn anything additional about developmental disability unless this topic was already prioritized within the organization.

Jenna said that support workers are encouraged to "get feedback" from other support workers and participate in "information sharing" with each other and with community organizations "**all** *(emphasis)* the time". However, Karen is unsure whether the resources her organization has that pertain to developmental disability are actually being used by other workers. She said that she only "happened in to all of this," that is, resources and support for women who have developmental disabilities, when she started working with a woman who has a developmental disability.

Though the sexual assault support workers and their organization seem to construct disability as less important than other identities, they are reflexive and question the actions of themselves and their organization. Karen and Jenna both made several statements acknowledging their able-bodied privilege, emphasizing that they can only speak for themselves, not on behalf of women who have a developmental disability. Jenna expressed concern that her organization may be reproducing oppression by not doing enough to be accessible to all women. Reflecting on her role, she asked:

> Sexual assault support workers, and counsellors, have we equipped ourselves with enough tools to be able to support….or are we still thinking in very mainstream ways where…we're not being conscious of who walks in our door and who doesn't? And, door, I mean that loosely; in the many ways that you can access support….Are we part of the problem, are we continuing to be part of the problem, or are we working toward a solution?

This statement indicates some level of ongoing commitment to improving services for women who have a developmental disability. Indeed, Karen and Jenna spent much of the time during their interviews reflecting on how accessible their organization is. They both acknowledged that there are "different types of accessibility," and that physical barriers to accessibility are only one aspect to consider. Karen said that she has had survivors access their services with the help of friends and parents, but that they try to adapt so that the survivor can access the services by herself:

> We've had people [accompany the survivor] for the first session….The first session [addresses] why the woman is here and then [we ask], 'Can we now have space with the woman herself to talk, if she's comfortable with that?' So we start with either one session or half a session with somebody, and then that person leaves. I've never had individual sessions go on with somebody else in the room, because we've usually just adapted to what that woman needs. Now, if a woman said, 'I will **only** *(emphasis)* communicate through this person, then we would let them stay, but…as far as I know, in my experience anyway, we haven't had that….I haven't had the experience with someone with an ASL [American Sign Language] interpreter; I could see that being [a situation where the accompanying person would stay for multiple sessions].

Karen's comments indicate a willingness to compromise in order to be accessible and create a comfortable environment for service users, while still allowing for confidentiality.

Jenna spoke about the workers' attempts to assess whether they are doing enough to be accessible:

> Are we making ourselves accessible in terms of our pub ed [public education] materials? Our website? What are we doing to ensure that the information gets out there in an accessible way? These are constant conversations we're having.

Jenna acknowledges that getting the word out about their organization is an important part of being accessible, because oppression affects the ability to obtain information about support services:

> I think [oppression] influences women's lives in so many ways. How they access us, right? Being able to find us….you need to be able to know, 'Who can I call, who could I talk to, and they will tell me to go to [this organization]?' That in itself is a barrier. Is it as simple as just being able to Google it? Is it having a computer?...Just being able to access support…may be a challenge in itself. We try to make ourselves as visible as possible, but you have to know a way to find information about us, right? Because so many people have said, 'I never knew you existed.'

Jenna's comment that people did not know that her organization existed demonstrates the significance of accessible outreach. Disability workers Kevin, Brian and Stacy all mentioned similar concerns, stating that a lack of information about services is a barrier. Stacy linked this to the "social isolation" often experienced by people who have developmental disabilities:

> [Social isolation] increases your risk of experiencing abuse, for sure, but it also means, if something happens, who do you go to and who do you trust? Who can help you get the help you need?

In addition to isolation, Brian identified that "inability to access resources or not knowing what's out there" occurs when family members want to "ignore" and "forget" an assault. Lastly, the disability support workers stated that they do not know about feminist support model organizations to refer their service users to.

Sexual assault support worker Karen discussed difficulties surrounding her organization's referral policy and accessibility:

> …If somebody wants to use our services they have to call us themselves; we don't take referrals….So, if a social worker calls and says, 'I have someone here who needs counselling,' we say, 'Great, here's our number, here's the information about [the organization], have them call us.' We don't want women forced to come here.

Karen's statement about referrals is related to concerns raised by disability support workers Stacy and Kevin. Kevin said that there has been a delay in some of his service users accessing services because of "not knowing how to communicate," but that his organization has assisted them in accessing the services they need. Stacy's concerns were also related to communication:

> The…people we support, because they have a mild to moderate intellectual disability, it might be easier for them to navigate some of these services. I know that for a lot of them you have to self-refer. So, for the people **we** *(emphasis)* support, that's not a huge deal; they can self-refer or we can do it side by side, or we can support somebody to do that. But I wonder, for somebody who maybe doesn't communicate the same way, or doesn't speak using words, that would probably…present quite a barrier, and maybe finding some ways around that would be helpful. I get the sense that the sexual assault support organizations in [this city] are pretty amenable.

Despite Stacy's concerns, she has a positive impression of existing feminist support work organizations' willingness to find ways around the issue of communication. However, it is difficult for an organization to solve a problem that has such complex roots. This represents an area of potential concern regarding the sexual assault support organization's accessibility, particularly when considering women who do not have a disability support worker to assist them.

According to sexual assault support workers Karen and Jenna, their training sessions address accessible methods of communication, including verbal and non-verbal communication. Karen said that the trainees do "exercises" to practice communicating with someone who may not communicate in a typical way—for example, someone with a speech impediment or someone using a non-verbal method of communication. She also acknowledged the importance of understanding different ways of expressing emotions, giving the example of someone who laughs while discussing something embarrassing or upsetting. Additionally, Karen said that in her own experience, communicating using the service user's own language or terminology is an important aspect of accessibility:

> Using [the service user's] language, that was a big thing. A lot of times the women might have a way that **they** *(emphasis)* describe things, and that's the wording that I would use…

Hingsburger (1995) also notes that workers who support people who use an alternative mode of communication have a responsibility to "learn their language" (pp. 84-86). According to Jenna, though, some trainees apparently "struggle" with adapting to service users' needs:

> The reality is, if you want to be a support worker and you want to be as accessible as possible, whatever that may look like for the [service user], that means being able to adapt, and often it's a **struggle** *(emphasis)*, and we rely on [an] interpreter to be the one to communicate as opposed to sometimes taking the onus on ourselves to be able

> to follow through….I mean, that's just my perception…

This "struggle" shows that there are still improvements to be made regarding their organization's accessibility.

Karen and Jenna each brought up situations in which their organization could have done more to be accessible or inclusive. Karen explained how an attempt to run a support group for disabled women failed, and barriers were only identified after the fact. She believes that the time of year was a factor, as it had been scheduled for the winter, when it is more difficult for people with mobility impairments and those who rely on public transit to travel. Furthermore, Karen believes that the location—a gathering place that often hosts social activities—was a deterrent, because the participants might not want to discuss sexual violence with the people they also socialize with. In addition, Jenna critiqued some of the external initiatives that her organization has been involved with for their inability to address certain groups of marginalized women, including women who have a developmental disability.

Jenna briefly mentioned an instance in which her organization was criticized for not being accessible:

> As an organization, we have been held accountable for our lack of *(pause)* being more open to different ways of providing support….and being innovative in finding support for women with developmental disabilities. I really can't go into any more detail than that without breaking confidentiality.

Concerns about non-disability-specific organizations' ability to serve women who have developmental disabilities were raised by the disability support workers interviewed, as well. Diane, Stacy, Eric and Liz each stated that barriers are created when service providers lack knowledge about developmental disability or are fearful of working with people who have developmental disabilities. Sexual assault support worker Karen confirmed that support workers may be "intimidated" when supporting a woman who has a developmental disability if they have not done so before. Additionally, disability support worker Eric mentioned women's shelters, in particular, saying that he does not think "that people with developmental disabilities have access to those kind of shelters very frequently." The disability support workers' concerns about accessibility and Jenna's statement about being held accountable gives an idea of the divide between these two types of organizations.

Though Jenna considered her role in reinforcing oppression, she said that some other sexual assault support workers have difficulty doing this:

> It's very interesting. Often [workers] who are coming from...[a] strong feminist background are actually very reluctant, sometimes, to acknowledge when they're reproducing…oppression. The rhetoric or the knowledge is there, or so we think it's there, until we get challenged. There's a level of honesty, with some women, where they will…openly talk about how…unaware they were.

Jenna also mentioned workers' responsibility to "call out" oppression when they witness it. These examples show that just because workers "talk the talk," it does not mean that their theory is put into practice.

Jenna acknowledged that there is a "gap" in the services her organization offers, because women who have developmental disabilities are not accessing their services in proportionate numbers. She stated that they need to do "so much more work," that there are "attempts" to improve their services for all disabled women, and that the organization has made "a commitment" to expanding their outreach to all disabled women. However, at this time, disability occupies a lower priority at their organization.

"I Really Don't Think in Those Terms too Often": Lacking an Intersectional Analysis and Establishing the Primacy of Disability

For the most part, the disability support workers lacked an intersectional analysis. Whereas the sexual assault support workers acknowledged ableism as one type of oppression among others that influence survivors' experiences, disability support workers constructed disability as the most important identity, if not the only important identity. Even when probed, they indicated that they do not usually consider identities other than disability—as disability support worker Kevin said when asked about race, class, gender, and sexual orientation, "I really don't think in those terms too often."

Stacy represented an exception. When asked if the experience of sexual assault would differ based on aspects of a woman's identity other than disability, she specifically cited intersectionality:

> I'm sure it would be. It's all about intersecting oppression. How much power people have, and, yeah. And then trying to find support afterward, there are barriers. And [service users] may not always feel welcome.

However, Stacy's acknowledgement of intersectionality was not representative of all of the disability support workers.

According to the disability support workers, most of the service users at the organizations represented in the research are white. However, most of the workers did not engage in a race-based analysis. Kevin's statement that he does not "think in those terms too often" is indicative of "colour-blindness" (Frankenberg, 1993, p. 142). When speaking about obstacles to accessing services, Kevin stopped short of calling out racialized oppression in explicit terms:

> I think the world is still, not **racist** *(emphasis)*, but biased, prejudiced. And *(pause)* every role as a member of society, I think that people bring their own [identity] into it and their own strengths and weaknesses, prejudice being one of them. If you are truly an ethical person, you have to be self-aware *(pause)* and not compensate for your *(pause)* weaknesses but adapt to them and make the right choices, the moral, ethical choices. *(inhales deeply)*

Kevin's hesitation to use the word "racist" indicates that for him, the term connotes overt or "extreme" racism. He seems to have a desire to distance himself—and perhaps other "well-meaning" white people—from this overt racism, referring to insidious racism as generalized "prejudice." Brian also sought to distance his organization from racism:

> Race, culture-wise, we don't have as many [service users] who are from a more ethnic background, although we found in the last year with our newer [service users], more people have been referred to us from an ethnic background….Of course, we accept everyone. We're not racist. *(laughs)*

Upon noting that there are more white service users at his organization, Brian felt the need to explain that they "accept everyone" and are "not racist." He laughed when saying that the organization is, "of course," not racist—as though the prospect of them being racist is literally laughable.

Brian and Kevin made basic statements about factors other than disability affecting a survivor's experience of sexual assault. Kevin said that if a survivor had a developmental disability and was "a minority," that would "make it worse," whereas Brian said that "disability or not, I guess race and ethnicity…it all comes into play." While Kevin's statement implies an additive approach to identity, Brian goes on to acknowledge a situation in which intersectional oppression affected one of his service users:

> Some women…with an intellectual disability, [because of their] cultural background, I know…they're not allowed to take the bus, not because they have an intellectual disability but because they're a woman, and [their parents] don't like that. 'She's on her own, she's young, she shouldn't be doing that.' So that makes things different; how are you going to access things in the community if you can't even take the bus? That's important; it makes things less accessible.

This example shows how, according to Brian, cultural norms, sexism, and ableism intersect and affect a service user's life and access to services. The factors he mentioned are also related to vulnerablization and could have a direct impact on a woman's experience of sexual assault.

When asked about race and potential obstacles to services, Diane said:

> [Other cities have] much more people of diverse backgrounds, and…I found [this city] to be very *(pause)* white, Anglo-Saxon….I haven't really heard of any race issues or things like that, so I really can't say I know.

Diane stops short of identifying the comparative lack of racial diversity in the city as a potential issue for service users of colour, and states that she is unaware of any "race issues." However, rather than dismissing race when asked, she acknowledges that she does not know what impact it may have.

A number of the disability support workers acknowledged that many women who have a developmental disability live in poverty. Stacy, Kevin, Diane, Eric and Liz acknowledged that their service users' economic status may negatively affect their ability to access services. Eric stated that the service users at his organization traditionally came from families who were "fairly poor," but was "surprised" to note that they have recently been accepting more service users from upper class families. The reasons behind or the implications of this shift were unclear in the interview, however.

Kevin and Stacy each acknowledged that some of their service users are criminalized. Stacy said that her organization:

> …support[s] a lot of people who find themselves in pretty sticky situations in terms of trouble with the law.

Kevin stated that some of his organization's service users are "closer to the street culture" but does not link this to issues of class; rather, he links it to criminalized service users, saying that many are involved with the city's detention centre. Both Stacy and Kevin raised concerns regarding the criminal justice system—as mentioned earlier in the chapter, Kevin said that he has his "biases about the police, the **legal system** *(critical tone)*" and Stacy acknowledged that survivors do not always have positive experiences with the police. While Stacy said that this makes her "uncomfortable," for the most part, these concerns were not linked to the mandatory reporting policies in place at their organizations. Furthermore, they did not consider how service users' prior experiences of criminalization would influence their experience of reporting an assault to the police.

Overwhelmingly, the disability support workers de-gendered their service users as well as the issue of sexual assault. This de-gendering is consistent with Canadian federal and provincial policy of the last decade, in which "'violence against women' has been reframed through a new degendered discourse of 'victims' issues'" (Beres et al., 2009, p. 144). This first became evident when the workers were asked whether their organizations had any programming specifically for women; they each seemed almost surprised at the question. The workers then proceeded to emphasize that all of their programming is available to all service users, regardless of sex or gender.

Disability support workers Diane and Liz each stated that their respective organizations list sexual assault policies under the generic category of abuse. Regarding her organization's policies, Diane said:

> We do have specific policies related to abuse, and within there, there's sexual abuse. And we'll probably have a sheet that's specific to sexual assault, but it's probably merged within that document [about abuse in general].

Liz made a similar comment:

> We felt that any sort of assault was assault and so we thought, in that context, it made sense to have how we would respond to any assault be…together.

The "merging" of policies about abuse and the assertion that "assault is assault" removes gendered aspects of sexual assault. By treating types of abuse as, essentially, the same, it also dismisses any potential differences in experience related to other marginalized identities. Liz later clarified that there are specific sections for physical, sexual, and emotional abuse within her organization's policy, but the consolidated policy she originally spoke about indicates that she—and potentially her organization—thinks about and responds to each distinct type of abuse in a similar way. Furthermore, when discussing the reactions of her organization's employees to the quality assurance measures mandatory reporting policy, Diane gave an example related to physical assault rather than sexual assault, indicating that she also thinks about these issues together.

There were few instances in which workers acknowledged that gender influenced specific issues. Liz and Eric said that there are rules about what male workers can and cannot do when assisting female service users—for example, they are not permitted to do personal care, such as bathing. This policy is hetero-normative and based on the gender binary, and it does not account for transgender workers or service users. Regarding his organization's abuse prevention training, Kevin said:

> …That's done in group sessions, but there are times, there are sections where…from my understanding, it would be segregated [by sex] just to allow for a more comfortable feeling for the participants.

On some level, he acknowledged that sexual assault is gendered—otherwise, they would have no reason to separate service users based on sex. Again, however, this practice does not account for transgender service users.

By de-gendering service users and the issue of sexual assault, the disability support workers fail to acknowledge the gendered nature of sexual violence and the lived experiences of many survivors. Then, by gendering specific, isolated issues like sex education and personal care, they acknowledge—whether consciously or subconsciously—that these issues do affect people differently based on gender.

Summary

Sexual assault support workers and disability support workers both resisted and reproduced ableist constructions with respect to speaking for or with service users. They also had conflicting views on the need for confidentiality, vulnerablization and medicalization. At times, they resisted and reproduced the same constructions. Similarly, in relation to the re-victimizing constructions of disbelief, victim blaming and responsibilization, and avoiding the subject of sexual assault, the workers sometimes constructed their service users in contradictory ways. Lastly, the workers constructed their service users' identities in contrasting ways. Despite their reflexivity and knowledge of intersectionality, the sexual assault support workers constructed disability as a less important identity. The disability support workers constructed disability as the most important or only important identity but, for the most part, they did not acknowledge the effect of intersectionality on their service users' lives.

The following chapter will discuss the implications of these findings in relation to this field of research and service delivery.

Chapter 6—Discussion

Throughout the interviews, there was a complicated relationship between resisting and reproducing ableist and re-victimizing constructions, as resistance and reproduction often occurred simultaneously. The workers sometimes constructed their service users in similar ways, but other times, their constructions and the ensuing approaches to service delivery deviated substantially. The issues discussed in this chapter show that there is a significant divide between the philosophies of the two types of organizations, which must be lessened if these types of organizations are to work together.

The first section of this chapter will discuss how sexual assault support workers and disability support workers constructed their service users in relation to oppressive social constructions of women who have a developmental disability and sexual assault survivors. The second section of this chapter will discuss sexual assault support workers' construction of disability as a less important identity to focus on, and how this was either acknowledged or ignored through the interviews. It will also discuss disability support workers' construction of disability as the most important identity, and how their lack of consideration of intersectional oppression is reflected in their acceptance of the mandatory reporting policy, their de-gendering of sexual assault and, subsequently, their support of the medical model.

Contradictory Constructions: Resisting and Reproducing Oppressive Constructions and Myths

The workers interviewed demonstrated resistance to many of the oppressive social constructions discussed in this section. However, their resistance was not always consistent, as they sometimes reinforced the same constructions. Furthermore, sexual assault support workers and disability support workers often constructed their service users in opposing ways. Both groups of workers constructed their service users as able to and worthy of making their own decisions and speaking for themselves, though disability support workers sometimes contradicted this, notably with regard to the mandatory reporting policy and medicalization. Sexual assault support workers constructed their service users as more worthy of strict confidentiality than disability support workers did; the disability support workers were more likely to believe that certain limits to confidentiality should exist. Both groups of workers resisted constructions of their service users as vulnerable, but disability support workers sometimes contradicted this by constructing their service users as needing protection, or by underestimating the need for training on the subject of sexual assault. The sexual assault support workers resisted medicalization, whereas the disability support workers medicalized their service users and the issue of sexual assault, despite expressing many concerns about the medical model. Lastly, both groups of workers rejected re-victimizing constructions, such as disbelief, victim blaming and responsibilization, but disability support workers occasionally reproduced these constructions and seemed unaware that they were doing so.

Speaking For or Speaking With?

Dudley (1987) contends that it is necessary for disability support workers to challenge the construction of people who have developmental disabilities as "incapable of thinking, speaking, and acting for themselves" (p. 81). In the interviews, the disability support workers and sexual assault support workers report that they do resist these stereotypes. The workers construct their service users as people who can and should be supported to make their own decisions and speak for themselves. This is reflected in the workers' statements in support of person-centred ideology. This is significant due to widespread infantilization of people who have developmental disabilities. Other disability support workers may not embrace person-centred ideology (Maes, 2003), and some infantilize service users "by denying their input into decision making" (Dudley, 1987, p. 81). Indeed, sexual assault support worker Karen stated that in her experience, disability support workers "often" speak for their service users when accessing support services. In the context of this persisting infantilization, the interviewees' resistance represents a commitment to supporting their service users' autonomy.

However, the mandatory reporting policy that disability support organizations must comply with causes a conflict for disability support workers. The policy itself is infantilizing, as it does not allow a service user to make their own decision about whether they would like to report to the police. It makes the paternalistic assumption that contacting police is in the best interest of the service user. During the interviews, Stacy was the only disability support worker to directly acknowledge and discuss this conflict, albeit briefly, though she did state that some volunteers at her organization have also raised concerns regarding it. The other disability support workers did not seem to link their desire to avoid speaking for their service users to the mandatory reporting policy. The workers have little choice but to comply with this policy, as they are required to do so by law. Even so, they did not seem to challenge or question it. When disability support worker Liz spoke of consent, emphasizing that "if someone says no, it's no" and that a service user's statement of no "will be honoured," she did not seem to consider the implications of this in relation to mandatory reporting. If a service user asked Liz not to report an assault to the police, she would not be able to honour this request. The finality of "no" is contradicted in this scenario, which is particularly problematic in the context of sexual assault. Hingsburger (1995) writes that people who have a developmental disability are frequently "offered false choices. And when they choose wrongly they are made to change their mind" (p. 81). This "happens so commonly as to be epidemic in human services" and because of this, service users learn that "no does not mean no….probably hundreds of times a week," causing confusion and a lack of confidence in their own words (Hingsburger, 1995, p. 81). Disability support worker Brian also uncovers a contradiction, saying that during the reporting process, service users would be "in the conversation the whole time" and that the workers would not be "going behind their [service users'] backs." If a service user had asked him not to report the assault, the service user would not truly be "in the conversation;" this shows that Brian does not acknowledge that he would be speaking for a service user if this occurred.

It is difficult to know whether the disability support workers' lack of criticism regarding mandatory reporting is representative of their actual feelings about the legislation. It is possible that they could have refrained from criticizing it during the interviews, fearing consequences for sharing these views with an "outsider." However, if workers do not criticize this policy, it will not change, and workers will continue to be required to "speak for" their service users in this circumstance. This is easier said than done, considering that the government has the ability to cut funding and close disability support organizations, subsequently putting the workers and their colleagues out of a job, and leaving one less organization to assist their service users.

Disability support worker Stacy stated during the interview that she "understand[s] why that [mandatory reporting policy] is in place," alluding to the history of institutional staff hiding abuse. Sobsey (1994) states that institutions and organizations serving people who have developmental disabilities have historically had a "strong philosophy of nonreporting" (p. 100). He explains how institutions have engaged in "the cover-up":

> Staff with knowledge of abuse do not usually report it to their supervisors. Supervisors and administrators who are aware of abuse sometimes attempt to control the problem internally, but when they do, they avoid taking any action that could lead to public recognition (Sobsey, 1994, pp. 91-92).

Institutions have often "trivialized" assault "as institutional or administrative infractions to be handled by employee relations," even when such incidents would be police matters among the general public (Sobsey, 1994, p. 104). This history could be used to justify the mandatory reporting policy, positioning it as beneficial for people who have a developmental disability.

Despite the long and damaging history of institutional cover-ups, the mandatory reporting policy is still ableist and infantilizing. For the most part, people who do not have a developmental disability are not forced to report abuse to the police against their will, and most choose not to report (Beres, Crow & Gotell, 2009, p. 144). It also assumes that people who have a developmental disability do not know what is best for themselves. Mandatory reporting policies can also cause harm in other ways. The criminal justice system's mistreatment of survivors as well as the way that disability influences criminalization will be discussed later in this chapter. In addition to these issues, Sobsey (1994) argues that "overreacting" to relatively minor complaints, such as workers defending themselves against an attack by a service user, "can be as dangerous as ignoring them" (p. 105). He writes that this "may erode the line between serious and minor or questionable offenses and increase the chance that more force will be used next time as the consequences would be the same" (Sobsey, 1994, p. 105). The disability support workers interviewed were clear that absolutely all instances of assault or suspected assault must be reported to police. Though Sobsey's example deals with physical assault, the concept of "overreacting" could be applied to the mandatory reporting policy, as well. Lastly, it is important to consider that "as an overall strategy for ending violence, criminalization has not worked" (Critical Resistance & INCITE! Women of Color Against Violence, 2006, p. 223). As such, it seems that despite the workers' apparent acceptance, the mandatory reporting policy is a misguided response to the issue of sexual assault against women who have a developmental disability.

Confidentiality

Based on the interviews, the sexual assault support workers and disability support workers seem to have different ideas or standards regarding confidentiality. The sexual assault support workers' policy is strict; as Karen said, they will not even divulge whether a service user is still attending her support sessions. As such, they construct their service users as worthy of strict confidentiality policies, regardless of whether they have a developmental disability or are non-disabled. However, the disability support workers seem to be more willing to divulge confidential information, and have a sense of entitlement regarding what occurs during their service users' counselling or support sessions, thereby constructing their service users as less in need of strict confidentiality policies.

Within their own organizations, the disability support workers seem to prioritize confidentiality less than the sexual assault support workers. Three disability support workers spoke of informing others within their organizations upon learning that a service user had been assaulted. Brian described this as "everyone [having] a right to know," indicating that a service user's right to confidentiality is considered less important than the employees' supposed "right to know" about someone's assault. Another issue emerged when Brian discussed the service users' inability to withdraw consent once they have signed his organization's "disclosure" form. This does not take into account the possibility of the service user not having understood or having misunderstood the form at the time of signing, not having had sufficient time to consult the document before signing it, or having been coerced to sign it. Brian stated that "it wouldn't be right" to withhold an assault disclosure from the service users' parents or caregivers if the disclosure form has been signed, even if the service user asked him not to. This would be particularly problematic if the service user had been pressured to sign the form by a parent or caregiver, who would then have access to otherwise confidential information about the service user. The inability to withdraw consent suggests an infantilizing belief that a survivor who has a developmental disability does not know what is best for herself.

In the interviews, the sexual assault support workers seemed to respect a service user's right to not have information about their support sessions shared with others. They were both frustrated by disability support workers' attempts to undermine confidentiality. Meanwhile, disability support worker Eric was frustrated about not being able to obtain this information, and disability support worker Liz spoke of the benefits of practitioners who have less strict confidentiality policies than the sexual assault support workers. The two groups of workers have opposing views on confidentiality, making it more difficult for them to reach common ground and "work together," as Eric hoped for.

As mentioned in Chapter 5, the disability support workers' desire to know what is happening in their service users' support sessions may be indicative of implicit infantilizing attitudes (Robey, Beckley & Kirschner, 2006, p. 452). Presumably, the workers would expect complete confidentiality for themselves. However, it seems that they do not expect it for their service users. This could suggest that on some level, they believe that people who have a developmental disability are less deserving of confidentiality. This is reflected in the disability support workers' service delivery as a preference for medicalized services that are more willing to work as "a team," in the words of disability support worker Liz.

Vulnerablization and Protection

The disability support workers interviewed acknowledge and resist the vulnerablization of their service users. They recognize the pervasiveness of protection from sexual information and the construction of their service users as asexual (Canadian Down Syndrome Society, 1996; Clare, 2009, p. 138; Dotson, Stinson & Christian, 2003, p. 196; Hingsburger, 1995, pp. 16-20; Richards et al., 2009, p. 185). Their service delivery reflects their resistance to these myths through the open and welcoming environments they claim to foster. This was particularly evident in the case of Liz, who hoped that her organization's cultivation of an accepting environment would enable service users to trust the workers and feel comfortable discussing issues of sexuality with them. The sexual assault support workers interviewed also reject the myth of asexuality and note that many people who have developmental disabilities are denied the chance to learn about sexuality (Dotson et al., 2003, p. 196; Garland-Thomson, 2002, p. 266; Hingsburger, 1995, pp. 16-20; Kaufman, Silverberg & Odette, 2007, pp. 2-9; Siebers, 2008, p. 136; Wilkerson, 2011, p. 204). The workers' attitudes are reflected in their service delivery as a willingness to provide service users with comprehensive information about sexuality, as Karen described. The resistance demonstrated by these two groups of workers is significant due to the widespread devaluing, repressing and ignoring of the sexuality of people who have developmental disabilities.

Despite this resistance, the disability support workers sometimes reproduced vulnerablization. Disability support worker Diane, in particular, stated that she would likely be "more protective" of a service user who was accessing support services. She is concerned that the service providers would not be accommodating and accessible, and that this could have a detrimental effect on the service user—concerns that are supported by Artman & Daniels' (2010) claim that psychologists and psychiatrists receive little training on disability (pp. 442-443). The concern that practitioners do not have proper knowledge or experience regarding developmental disability could be another reasoning for disability support workers' attempts to find out what is occurring in their service users' support sessions, as discussed earlier in the chapter. Indeed, many of the disability support workers seem to want the best for their service users, but they need to move beyond a simplistic, patronizing understanding of "protection." As Dudley (1987) writes, "[ableist] misconceptions may lead professionals to protect their clients when they should be equipping their clients to face adversities" (p. 81). Rather than employing an approach of "protection" without problematizing that concept, Dudley's proposed course of action is proactive and has the potential to avoid vulnerablization.

Related to the reproduction of vulnerablization, the sexual assault support workers reported that some disability support workers they had encountered were not open to learning about abuse. This contradicts the accepting, sex positive, anti-vulnerablization accounts of the disability support workers interviewed. This contradiction could be due to the sample recruited for this study; it is possible that this sample is not representative of all disability support workers, as workers who are more open to learning about abuse may have been more likely to respond to a call for participants for a study on support services for sexual assault survivors. Regardless, sexual assault support worker Karen contended that some disability support workers do not know how to respond to survivors of sexual assault, and sexual assault support worker Jenna went so far as to say that among some disability support workers, there is a "complete denial" of needing such information. If disability support workers believe that they do not need the information themselves, it seems unlikely that they would believe their service users to be in need of the information. If disability support workers do not believe that they require training on how to deal with sexual assault or do not have adequate training on the subject, the dismissive attitudes that Karen and Jenna spoke of are unlikely to be challenged or changed.

The disability support workers interviewed report not having dealt with many disclosures of sexual assault, if any at all. If service users are not disclosing assault to staff, it is possible that this is causing disability support workers to believe that assault is less common than it really is, despite their knowledge of the statistics. This could partially explain the denial of needing information on abuse that was reported by the sexual assault support workers. The accounts of having heard few disclosures raises the question as to why service users are not disclosing their experiences of assault. It is possible that the atmosphere at the disability support workers' organizations is not as open as they perceive it to be. Furthermore, the mandatory reporting policy could present a deterrent for survivors who do not wish to report to the police. It is also possible that disability support workers' unwittingly reproduce victim blaming sentiments, potentially eroding their service users' trust in them, as will be discussed later in this chapter.

Considering disability support worker Liz's statement that all of the women at her organization who have lived in institutions have been assaulted, disability support workers should be aware of the likelihood that their service users have experienced assault in the past. It is important for workers to note that not all survivors discuss their assault soon after it has occurred, nor does healing happen within a set time frame. Therefore, even if service users are not disclosing, or if disclosures are of historical assaults, these service users may still benefit from sexual assault support services, and workers should be prepared for this.

Medicalization

Medicalization represents a major divide between the philosophies of sexual assault support workers and disability support workers. The sexual assault support workers opposed and resisted medicalization, which was to be expected, as the feminist support work model exists as an alternative to the medical model. Their opposition is reflected in their service delivery in a number of ways. For instance, Jenna reported a resistance of medicalized labels, intending to create a safer environment for people whose labels have restricted their access to other organizations. The sexual assault support workers noted that services that charge a fee are inaccessible for many women who have a disability and identified this as a reason that disabled women access their services. However, the fact that their services are free of charge is not specific to their organization but is indicative of the feminist support work model as a whole. Their resistance to medicalization is also demonstrated through their willingness to accompany service users to medical appointments, which Karen feels increases the practitioners' accountability. In Dotson, Stinson and Christian's (2003) study of women with developmental disabilities and their personal perspectives on health care, participants reported that medical practitioners can be ableist and inaccessible, particularly by using complicated language that they do not understand or failing to provide relevant care, such as performing Pap tests or explaining how to perform a breast self-exam (pp. 204-207). The increase in accountability that Karen perceived may alleviate some of the ableism identified in Dotson, Stinson and Christian's study, showing the significance of the sexual assault support workers' willingness to accompany service users to appointments.

There were some ways in which disability support workers resisted medicalization. Like the sexual assault support workers, disability support worker Kevin seemed to resist medicalized labels as well as the pathologizing of sexual assault. Liz's acceptance of one service user's refusal to see a psychologist or psychiatrist resisted the medicalized belief that people should always seek medical attention, while also resisting infantilization by acknowledging that he has the right to make his own medical decisions. The significance of these acts of resistance is underscored by the other disability support workers' reproduction of pathologizing constructions.

Despite these instances of resistance, the disability support workers reinforce medicalization in many other ways. They uphold the medicalization of sexual assault by assuming that survivors need to seek medical attention after an assault and by defaulting to psychology and psychiatry in discussions of support. In doing so, they fail to acknowledge the sexist history of the medicalization and pathologizing of women's bodies (Lorentzen, 2008, pp. 51-52), as well as the violent history of medicalization against women who have developmental disabilities, among many other marginalized women (Block, 2000; Desjardins, 2012; Hubbard, 1990, p. 95; Smith, 2005). This will be discussed in the context of intersectionality later in this chapter. The workers also did not seem to consider the potential harm of re-victimization within the medical model, in which "survivors are frequently denied the very assistance they seek" and are often "treated poorly by system personnel" (Greeson & Campbell, 2011, p. 582).

The disability support workers' reinforcement of medicalization is reflected in their service delivery by the fact that all but one reported knowing little, if anything at all, about alternatives to the medical model. It is also evidenced in their hesitancy to allow service users to make medical decisions for themselves. Disability support worker Brian attributed this to a concern for the service users' "well-being," but his idea of well-being did not take the medical model's tendency to re-victimize into account. The workers also perpetuated medicalization by believing that seeking medical attention is in a service user's best interest, without seeming to consider alternative models and responses, such as the feminist support work model.

A paradox emerged in which the disability support workers heavily criticized many aspects of the medical model, yet continued to rely on it without seeking alternatives. They stated that their service users should have a choice between disability-specific and generalized services, but expressed frustration that they must rely on specialized services because so many practitioners in generalized services are ableist and do not know how to work with people who have developmental disabilities. Eric, in particular, seemed to distrust generalized services, despite saying that he prefers them. He did not believe that generalized services have sufficient resources to adequately respond to people who have a developmental disability. As such, it might be unlikely that he would consider the feminist support work model, unless they offered specific services for women who have a developmental disability. Furthermore, Liz and Stacy denounced ableist medical professionals, yet continued to privilege medical professionals, despite the realization that just because one is a "professional," they do not necessarily have the required knowledge to work respectfully with all people. Even though workers constructed their service users as worthy of any service available to the general population, they remained focused on the medical model. Another widespread criticism of the medical model was the cost. The disability support workers believed that the fees charged by medicalized services are too high for most, if not all, of their service users. This concern is generally not reflected in their service delivery; though Liz stated that her organization assists service users with the cost of medicalized services, the other workers did not mention this, nor did they acknowledge that models which provide services free of charge could alleviate some financial pressure. Lastly, the disability support workers criticized the wait times of medicalized services without taking note of alternatives that may have shorter wait times. Diane was particularly concerned by wait times, as she thought her organization may not have been doing enough to train workers on the long term effects of sexual assault. This type of training is especially important if survivors are not accessing services in a timely fashion.

Despite the irony in continually prioritizing and trusting a system that they so widely criticize, the disability support workers' reliance on the medical model is not particularly surprising. The pervasive belief that medical professionals are the only people to be trusted regarding matters of the body is linked to the construction of disabled bodies as abnormal and "in need of treatment" (Biklen, 1988, p. 128; Todd, 1989, pp. 12-13). Disability support workers do not necessarily have any background in critical disability studies; therefore, it could be expected that they would work from a perspective that is at least partially influenced by medicalization. Western society privileges the medical model (Lorentzen, 2008, p. 53), and this privileging is reflected in the disability support workers' service delivery.

The divide between sexual assault support workers and disability support workers on issues of medicalization points to a weakness in the links between these two types of organizations. Stacy was the lone disability support worker to have knowledge about the feminist support work model; she attributed this to a partnership that her organization had undertaken with a local support work organization. When discussing her experiences with that organization, she seemed enthusiastic and positive, noting that they seemed "inclusive." She also said that she has since referred service users to that organization, indicating that she trusts them to have knowledge about developmental disability. Stacy's knowledge of and positive attitude regarding the feminist support work model shows that outreach initiatives between these two types of organizations can be beneficial. However, despite Stacy's knowledge of this model, the other worker from her organization did not exhibit the same knowledge about this model, indicating that training and other information may not be shared effectively within these organizations.

As mentioned earlier in the chapter, disability support workers Eric and Liz expressed a desire to work together with support providers, though Eric perceived confidentiality policies to be a barrier to this goal. As evidenced by disability support worker Stacy's accounts of working with a feminist support work organization, such partnerships can be successful. However, sexual assault support worker Jenna said that her organization has experienced mixed results when conducting outreach to disability support organizations. According to Jenna, the workers are sometimes appreciative of the information, but other times, they do not acknowledge a need for it, making the outreach "very difficult." Jenna also stated that her organization does not always receive replies from disability support organizations that they attempt to connect with. This lack of response, along with the "difficult" outreach she described, shows that some disability support organizations are not receptive to sexual assault support organizations. It is impossible to know whether this is because they do not acknowledge the need for abuse prevention initiatives, because they reject alternatives to the medical model, because they do not have the funding or time required to take on another initiative, or another reason entirely. Regardless, if these two types of organizations are to bridge the gap that exists between them, the issues causing this gap need to be identified and the organizations need to, somehow, find common ground.

Re-victimization

The tendency to not believe survivors of sexual assault was rejected by the sexual assault support workers and, for the most part, the disability support workers. Both groups of workers were particularly concerned with the criminal justice system's (mis)treatment of survivors, though they also mentioned disbelief in relation to the medical model.

Though the mandatory reporting policy is intended to protect service users, the police cannot be guaranteed to respond in a positive way. Sobsey (1994) states that: "even when authorities beyond the confines of an institution become aware of abuse, they often respond by referring the problem back to 'institutional authorities'" (p. 92). Indeed, disability support worker Stacy doubts that the Ministry of Community and Social Services consulted police before implementing the mandatory reporting policy, as she said that the police often respond with confusion when receiving a report from disability support workers, asking, "Why are you calling us with this?" This indicates that the police believe that these reports are not something they should be handling. This concern was echoed by sexual assault support worker Karen and disability support worker Kevin, both of whom lack faith in the criminal justice system and believe that the police do not take reports of sexual assault against women who have a developmental disability seriously.

Sexual assault support worker Jenna and disability support workers Kevin, Liz and Stacy all criticize the criminal justice system for infantilizing people who have a developmental disability by declaring them to be "incompetent" witnesses. Each of these workers construct their service users as competent and just as worthy of access to the criminal justice system as people who do not have a developmental disability. This is reflected in the service delivery of each of the organizations, as they support their service users in the process of pursuing criminal charges. The sexual assault support organization respects the wishes of service users who do not wish to report to police or press charges, whereas the disability support organizations are required to report, regardless of service users' wishes, by the mandatory reporting policy.

Though the disability support workers acknowledged the harm that could be done by having the criminal justice system deem a service user "incompetent," they did not link this concern to the mandatory reporting policy. Furthermore, disability support worker Liz stated that service users at her organization "have the authority to say no, and that that will be honoured, and that you will not have implications beyond here." Not only did she fail to link this to the fact that mandatory reporting does not respect a service user's "no," but she did not acknowledge that the criminal justice system's re-victimizing treatment of survivors certainly represents an "implication beyond [the organization]."

The disability support workers also rejected disbelief perpetrated by counsellors and clinicians. Eric and Brian each emphasized the importance of survivors having a trusting, empathetic environment in which to seek support. Brian said that service users often feel misunderstood and as though "no one cares about [them];" if service users already feel ignored, misunderstood and, therefore, not believed, an empathetic and trusting setting is essential for preventing re-victimization. However, disability support workers continue to privilege the medical model, and this type of nonjudgmental setting is not guaranteed within the medical model.

Despite stating in the interviews that they reject disbelief, some disability support workers may also reinforce it. Sexual assault support worker Karen said that service users have told her about not being believed by the staff at their group homes. Disability support worker Eric talked about "proof" of assault and "corroborating" a survivor's story; the use of this doubting terminology is in line with Karen's anecdote. Eric did not seem to acknowledge that the use of these terms could be construed as disbelief and, as such, be re-victimizing. Furthermore, Eric appeared to underestimate the possibility of survivors facing disbelief when attempting to access services through the medical model. He seemed to assume that a survivor who has a developmental disability would have no or little difficulty accessing the service in the first place, and stated that they "might even get more sympathy, a more quick response, because they're vulnerable." This is not reflective of the larger culture of disbelief that surrounds survivors of sexual assault, particularly survivors who have a developmental disability. As such, it seems that Eric underestimates the barriers that a survivor might face in accessing support services, which could lead to a lack of adequate support from his organization.

The sexual assault support workers resisted victim blaming. This is reflected by the fact that they do not focus on survivors' vulnerability, or their need to protect themselves, but instead focus on perpetrators' power. Never blaming a survivor for an assault is part of the basis of the feminist support work model. However, they were not alone in focusing on perpetrators, as the disability support workers often did so as well. Disability support workers Liz, Stacy and Brian acknowledged that sexual assault is about power relations, and Liz and Eric both insisted that workers are responsible for preventing sexual violence. It is hoped that these attitudes are reflected in their service delivery.

Though the disability support workers rejected vulnerablization, they perpetuated victim blaming and responsibilizing narratives, seemingly unwittingly. The disability support organizations have undertaken important and necessary initiatives to educate service users about sexuality and abuse. However, these initiatives focus too much on self-protection, putting the responsibility for preventing assault on the service user. Hollomotz (2009) claims that this is an insufficient approach and argues for a more widespread, societal approach, stating that "instead of focusing just on the individual, we must also aim to find universalistic solutions to reduce risk of sexual violence," and that it is important to "take the pressure for change off the individual and re-focus it on the environment" (p. 108). Hollomotz's perspective is not consistent with the disability support workers' current service delivery.

Other seemingly unintended victim blaming statements are also significant. By saying that a service user "left herself vulnerable," to use an example from Eric's interview, the worker is "laying the blame for the victimization inside of the person" and assuming that "the source of the assault is lodged somewhere inside [the survivor]" (Hingsburger, 1995, p. 16). Furthermore, workers need to take a more direct stand against abuse of power—for example, Brian's description of an abuse of power as only "unfortunate" rather than "unacceptable" does not truly denounce harmful power dynamics. Stronger opposition is necessary to upset the system of power; as Hollomotz (2009) writes, "if we challenge unequal power relations, we challenge conditions that create opportunities for sexual violence" (p. 109). If Brian is actually opposed to the mistreatment of people who have a developmental disability by people who wield disproportionate power, he needs to take a more definitive stance. Without doing this, ableist and rape-supportive attitudes will remain unchallenged.

The workers seemed to know that victim blaming is a societal problem, and the use of victim blaming language by disability support workers seemed to be inadvertent. However, a lack of intention does not negate the fact that these statements may have an impact on service users who overhear them. If these workers did not realize that they were making victim blaming remarks during the interviews, this could mean that the workers are making such statements in front of actual survivors. Victim blaming language and euphemisms that deemphasize the coercive, violent nature of sexual violence could be internalized by service users, potentially exacerbating the "self-blame" that disability support workers Kevin and Liz have witnessed. It could also be a reason why service users are not disclosing assault to disability support workers more frequently.

The disability support workers sometimes engaged in the practice of shifting the focus from survivors onto people who have a developmental disability as perpetrators perpetuates the myth of hypersexuality (Block, 2000, p. 242-244; Richards et al., 2009, p. 185) and takes the focus away from survivors. While perpetrators of sexual assault who have developmental disabilities should have access to appropriate resources, this receives a disproportionate amount of attention. According to disability support worker Eric, this is reflected in other organizations' service delivery, as he believes that there are more resources for perpetrators who have a developmental disability than for survivors. This shows that focus-shifting is detrimental to people who have a developmental disability, not only because it perpetuates a myth, but because it limits available services for survivors. However, the lack of services that Eric perceived could possibly be improved if the disability support workers acknowledged services available through the feminist support work model.

Summary

The stereotypes that sexual assault support workers and disability support workers resisted and reinforced are all socially constructed, and their resistance and reinforcement also takes place within a socially constructed context. As such, the two groups of workers often had opposing views, and the workers frequently contradicted themselves by simultaneously resisting and reproducing the same constructions. The many contradictions uncovered in the interviews show that there is no single, definitive answer as to how service users are constructed by workers; rather, they are constantly constructed in multiple ways.

"Falling Through the Cracks:" Prioritizing and Deemphasizing Intersectional Identities

In the interviews, it emerged that sexual assault support workers prioritize other identities, such as gender and race, over disability, whereas the disability support workers constructed disability as the most or only important intersection. This is consistent with Eli Clare's (2009) criticism of the priorities of different groups of social justice activists. He writes, "I want nondisabled progressive activists to add disability to their political agenda. And at the same time I want disability activists to abandon their single-issue politics and strategies" (Clare, 2009, p. ix). Currently, few "disability or nondisabled progressive groups engage in multi-issue thinking and organizing that deeply embed disability politics into an agenda that includes race, class, gender, and sexuality" (Clare, 2009, p. x). Clare's concerns are exemplified by the interviewees' priorities. The sexual assault support workers' deemphasizing of disability was reflected in their service delivery as a lack of targeted services for women who have a developmental disability, and a lack of concern over the way that developmental disability is addressed in their training, with varying levels of self-criticism. Conversely, the disability support workers' overemphasizing of disability was reflected in their service delivery as a tendency to overlook the effect of other identities, especially with regard to their privileging of the medical model and de-gendering of sexual assault. The omissions by both groups of workers have the potential to allow service users to "fall through the cracks," a phrase disability support worker Stacy used during the interview.

Sexual Assault Support Workers and the Deemphasization of Disability

When asked if workers at her organization would be willing to support a woman who has a developmental disability, Jenna compared this to whether a worker would be willing to support a woman of colour, and said that "you have to be" willing. Her equating of ableism and racism demonstrates the commitment to intersectionality that the sexual assault support workers discussed, but this is not fully reflected in the organization's services and service delivery. Despite the rhetoric of intersectionality, disability is not equated with other experiences of oppression in the organization's day-to-day operations.

Despite offering programming targeted to certain groups of marginalized women, they do not offer targeted programming regarding disability in general or developmental disability specifically. Karen said that this is due to a lack of resources, and that doing outreach and targeting populations when they do not have the resources to support additional service users is "just not responsible." Disability support worker Liz was also concerned with the amount of sexual assault support services available, worrying that if all survivors from her organization sought support, the amount of services available would be insufficient. Based on Liz's concerns, Karen's wariness about specifically targeting additional populations seems justified. However, this still means that the organization is prioritizing certain marginalized women over others, thereby deemphasizing disability.

Based on what Karen and Jenna shared during the interviews, it seems that the sexual assault support workers' training sessions are insufficient in addressing developmental disability. While Karen said that disability is "woven into the…training," she also said that developmental disability is "not a main focus of our training." On the other hand, there are entire training sessions devoted to other marginalized identities. Though the sexual assault support workers were often reflexive and acknowledged their privilege, they did not acknowledge how privilege affects which additional training sessions their organization chooses to take on. Additional training sessions are conducted on topics of interest, which does not ensure that developmental disability will ever be addressed in these sessions, while the fact that they usually are not mandatory unless the topic is "really" important indicates that there is a hierarchy of issues. These concerns were not identified by the sexual assault support workers in the interviews. Furthermore, it may not be enough to simply have resources available to sexual assault support workers; Karen expressed a concern that other workers may not be using the organization's resources about developmental disability. She herself said that she only came across the information by chance after she had started supporting a woman who has a developmental disability. Only coming across resources about developmental disability by chance does nothing to promote accessibility.

The sexual assault support workers maintained that their organization is committed to an "intersectional, holistic approach," as Jenna described it. She asserted that it was important not to treat individual identities as independent from one another. While such an approach is consistent with feminist activism and scholarship, the organization seems to apply it inconsistently. Jenna stated that she believes the programs that they offer to specific groups of marginalized women are important, but she did not question whether they represent a departure from an intersectional, holistic approach. If programs of this sort do fit within this approach, workers need to be more critical about why they target some identities and not others, and examine whether they ever use intersectionality as a justification for not offering disability-specific services.

Karen and Jenna both seemed to be knowledgeable about accessibility and keen on learning how to be more accessible. Karen has supported women who have a developmental disability in the past and has experience adapting the way she provides support in order to suit the service user's needs. However, Jenna said that workers sometimes "struggle" with learning to communicate in alternative ways in order to support women who do not communicate verbally. When mentioning this "struggle" in the interview, Jenna did not state whether she believed workers were doing enough to ensure communication accessibility, leaving the possibility that some workers are not learning this information because they find it difficult—or perhaps even unnecessary. Furthermore, when Karen and Jenna mentioned initiatives their organization undertook or participated in that had failed to be adequately accessible, they did not indicate that the organization had attempted to fix these particular problems.

Jenna argued that her organization needs to engage in accessible outreach, as social isolation and resources in inaccessible formats can prevent women from learning about their services. She noted that many people "never knew [their organization] existed," and this includes many of the disability support workers interviewed for this thesis. Disability support workers are supposed to be knowledgeable about community resources. If they themselves do not know about the feminist support work model, it is unrealistic to expect the general public to be able to find this information easily, much less a survivor who has a developmental disability and is experiencing social isolation. These factors increase the importance of accessible outreach.

Despite the reflexivity demonstrated by Karen and Jenna during the interviews, Jenna said that some sexual assault support workers have a hard time with this and can be "reluctant" to admit when they are reproducing oppression. She claimed that workers are responsible for holding each other accountable and "calling out" oppressive statements and behaviour, however, it is unclear how likely they are to do this if workers are reluctant to recognize their own privilege. Additionally, taking note of what you have done wrong is an important step, but it is only one step—in order to right the wrong, the acknowledgement must be acted upon. Indeed, Jenna stated a concern that her organization might not be doing enough to promote accessibility and could even "be part of the problem." Though she said that the workers constantly assess this, in the interview she did not link this to the specific accessibility concerns that she mentioned, to the training, or to the programming they offer.

The sexual assault support workers demonstrated that they know the theory of intersectionality but, based on the information provided in the interviews, they are inconsistent in applying it to their work. They are aware that they need to improve their accessibility, particularly for women who have a developmental disability, but they downplayed this in relation to other issues, particularly their training procedures and the need for targeted services. It would seem from this information that they should devote specific attention to concerns about communication accessibility, particularly in relation to disability support workers' perception of their services, and to being proactive in not only recognizing oppression but acting on it.

Jenna stated that their organization has made "a commitment" to improving services for all disabled women, but unless this commitment is acted upon, disability will continue to be constructed as a less important identity within the organization.

Disability Support Workers and the Overemphasizing of Disability

As identified in chapter 5, the disability support workers constructed disability as the most important or significant experience of oppression while almost entirely neglecting their service users' other identities. They repeatedly acknowledged the widespread impact of ableism on their service users' lives, but they did not appear to extend their analyses to other experiences of oppression, thereby suggesting that they are largely unaware of the theory of intersectionality. The tendency to "not see" race that is common among white people in North America could partly explain the disability support workers' lack of a race-based analysis (Alegria, 2014, pp. 242-244; Frankenberg, 1993, pp. 142-145). If the workers do not pay attention to race out of a belief that this is the socially acceptable way to behave, they would not be equipped to consider the effects of systemic racism (Alegria, 2014, p. 242). This argument can be extended to other experiences of oppression, as well—workers who do not consider different types of discrimination cannot be expected to address their effects.

This is especially evident when dealing with the mandatory reporting policy and workers' adherence to the medical model.

The workers' failure to acknowledge the influence of identities other than disability is concerning when considering the mandatory reporting policy. Stacy and Kevin stated that a number of their service users, especially those who have a dual diagnosis, have been criminalized. The workers did not seem to acknowledge how disability intersects with identities such as race, gender, sexual orientation and class to influence service users' interactions with police, including how this may affect a service user who reports sexual assault. Disability increases a woman's likelihood of living in poverty, a fact that many of the disability workers mentioned, yet the workers did not link this to the criminalization of poverty (Critical Resistance & INCITE! Women of Color Against Violence, 2006, p. 226; DisAbled Women's Network of Canada, 2015). Mental illness, neurodivergence, and developmental disability are also criminalized, leading people who are labelled in these ways to be at higher risk of experiencing police brutality (Nelson, 2010, pp. 6-7, 10). The danger is magnified for people of colour who are identified as mentally ill, neurodivergent, or as having a developmental disability, as "the intersection of race and mental status [is] one that attracts heightened police scrutiny and which disparately leads to excessive use of police force" (Nelson, 2010, p. 63). Criminalization has caused many other people to be "brought…into conflict with the law," as well, particularly indigenous women, immigrant women, queer women, transgender people and sex workers (Critical Resistance & INCITE! Women of Color Against Violence, 2006, p. 223, 225). Therefore, disability increases the likelihood of encounters with police, but there is a higher chance that a service user who is also marginalized on the basis of gender, sexuality, race or class has had prior contact with police, contact which could have been violent.

A service user who has been involved with the criminal justice system in the past may not want to report an assault, in order to avoid dealing with the system again, but disability support workers who are made aware of assault have no choice in this matter. Mandatory reporting increases the service user's risk of being re-victimized, but it may also increase the likelihood that they will not disclose an assault to a support worker in the first place, if they are aware that the police will have to be involved. Mandatory reporting puts service users at risk of experiencing re-victimization and discrimination on the basis of several identities. At best, it is paternalistic and at worst, it is a new example of state-sanctioned oppression. It is deeply problematic that the disability support workers did not seem to take this into account and that they did not explicitly criticize the policy.

The disability support workers' de-gendering of their service users, of abuse policies and of sexual assault more broadly is consistent with federal and provincial policy on sexual assault and domestic violence. As these agencies are government-funded, this should not be surprising, however, such an approach is problematic. It ignores that the majority of sexual assault survivors are women and the majority of perpetrators are men, and fails to account for the ways in which misogyny and hetero-normative societal attitudes influence rape-supportive attitudes and re-victimization (Alsop, Fitzsimons & Lennon, 2002, p. 121; Johnson & Dawson, 2011, pp. 66-69; Kimmel, 2008b, p. 301; McCormick, 2010, p. 24; Redfern & Aune, 2010, p. 50). The possibility of offering gender-specific programming did not even seem to occur to the disability support workers, as evidenced by their expressions and tones of surprise when asked about this. The workers' lack of knowledge of the feminist support work model could then be seen as an extension of this de-gendering—if they do not treat sexual assault as a gendered issue, they may be less inclined to seek out a feminist response to it.

In the interviews, the disability support workers did not address the violent history of medicalization and many of the negative ways in which their service users might experience the medical model. This is demonstrated by the workers' medicalization of sexual assault and their continued reliance on the medical model in general. Within the medical model, women's bodies, transgender bodies and disabled bodies are pathologized, treated as abnormal in relation to the healthy, non-disabled male body and constructed as requiring treatment (Biklen, 1988, p. 128; Garland-Thomson, 2001, p. 10; Lorentzen, 2008, p. 51; Messing, 1995; Singh, Hays & Watson, 2011, pp. 20-21). Survivors of sexual assault who seek treatment within a model that marginalizes them may encounter oppression and re-victimization, and many survivors report that in their experience, the medical model did more harm than good (Greeson & Campbell, 2011, p. 582). In addition, eugenics programs and sterilization abuse have targeted many groups of marginalized people, especially women with developmental disabilities, but also indigenous women and other women of colour, transgender people, people dealing with addiction, sex workers, and people living in poverty (Amnesty International, 2014; Bierria, 2007, p. 154; Block, 2000; Desjardins, 2012; Hubbard, 1990, pp. 94-97; Malacrida, 2005; Nelson, 2013; Ralstin-Lewis, 2005; Rojas Durazo, 2006, p. 185; Smith, 2005; Wahlsten, 1997). Sterilization abuse continues today, even where it is no longer state-sanctioned (Bierria, 2007, p. 154; Desjardins, 2012; Smith, 2005). Despite this, the disability support workers did not seem to consider that privileging the medical model's response could be a problematic course of action, considering its history of violence and the possibility that it may be harmful to service users. While it may not be surprising that the disability support workers did not consider the impact of gender and other intersections in relation to the medical model, they did not outwardly link the ableism that they had witnessed from some service providers to the larger history of ableism within this model.

Summary

In the interviews, the sexual assault support workers and disability support workers demonstrated opposite emphases on intersectionality. Though the sexual assault support workers were knowledgeable about intersectionality, they constructed disability as less important than other identities, reflected in their service delivery as an absence of services targeted specifically toward women with disabilities of any kind, and a lack of concern over whether the structure and content of their training allow for further learning on the subject of developmental disability. At the same time, the disability support workers ignored the effect of identities other than disability, with few exceptions. Even though they put disability at the forefront, they did not always consider how ableism perpetuated by institutions such as the medical establishment and the criminal justice system would affect their service users. These issues were reflected in their service delivery as a lack of criticism of the mandatory reporting policy and the continued privileging of the medical model.

One sexual assault support worker and one disability support worker gave similar examples about service users who were unable to access services in the community, examples which reflect the shortcomings discussed in this section. Sexual assault support worker Jenna said that many of her service users have been turned away from other organizations because of the ways in which they are labelled, and disability support worker

Stacy pointed out that her organization serves "a lot of people who may have traditionally fallen through the cracks" because of the ways they have been labelled. This common concern exhibits the need for services that account for a diversity of identities and consider the effects of intersectional oppression. However, the workers interviewed for this thesis do not seem to notice that by emphasizing or deemphasizing certain identities, they themselves may be allowing women to "fall through the cracks."

Conclusion: Bridging the Gap and Filling In the Cracks

The sexual assault support workers and disability support workers interviewed often exhibited radically different views on issues of sexual assault and developmental disability. Though they each resisted many ableist and sexist social constructions and myths, others were reinforced. The resistance and reinforcement often occurred simultaneously, sometimes even dealing with the same construction, uncovering contradictions in the workers' beliefs and practice and demonstrating the complications of attempting to resist systemic oppression.

In order to bridge the gap between the two types of organizations, they will have to address their opposing views on various issues. Disability support organizations will have to be receptive to feminist support work organizations, and sexual assault support workers must pay close attention to the concerns of women who have developmental disabilities and disability support workers. The disability support workers interviewed largely assumed that the feminist support work model is not accessible for their service users, and sexual assault support worker Jenna mentioned that her organization has been criticized in this regard. If the sexual assault support workers do not heed disability support workers' concerns, the disability support workers will not trust them or view them as legitimate. However, disability support organizations must also be willing to learn from sexual assault support workers, something that sexual assault support worker Jenna identified as a barrier to past outreach. If the disability workers' privileging of the medical model and the lack of research on feminist support work for survivors who have a developmental disability is any indication, the sexual assault support workers face a significant amount of opposition. Bridging the gap to bring these types of organizations together will help to fill in the proverbial cracks that service users tend to fall through. This has the potential to improve the quality of service and, subsequently, the lives of women survivors who have a developmental disability.

Chapter 7—Conclusion

This thesis examined the ways that women survivors of sexual assault who have a developmental disability are constructed by sexual assault support workers and disability support workers in a medium-sized Ontario city. Two sexual assault support workers and six disability support workers participated in qualitative, feminist in-depth interviews. The interviews and data analysis were informed by feminist social constructionism, the social construction of disability, and intersectionality theory.

This thesis argued that the workers construct their service users in multiple, sometimes conflicting, ways, and that the two groups of workers often construct the service users in opposing ways. This opposition demonstrates that significant gaps exist between sexual assault support organizations and disability support organizations. Both groups of workers constructed their service users as deserving and able to make their own decisions about their lives. At the same time, disability workers sometimes reinforced ableist assumptions that people who have a developmental disability should not make their own decisions by failing to challenge the mandatory reporting policy. The sexual assault support workers constructed women who have a developmental disability as worthy of the same strict confidentiality as their service users who do not have a developmental disability, whereas disability support workers constructed their service users as requiring less confidential services, both within their own organizations and when accessing mental health services. The sexual assault support workers resisted vulnerablizing constructions, whereas disability support workers both resisted and reproduced this construction. The sexual assault support workers rejected the medicalization of their service users, but the disability support workers mostly upheld medicalized constructions of their service users, especially with regard to sexual assault. Both groups of workers resisted re-victimizing constructions of survivors of sexual assault—namely the tendencies to not believe survivors, to blame and responsibilize survivors, and to shift the focus away from survivors by avoiding the subject of sexual assault. Despite rejecting these constructions, the disability support workers sometimes upheld them through their language, though they did not seem to realize this. Finally, the two groups of workers had opposing views on intersectionality. Despite claiming to prioritize intersectionality, the sexual assault support workers constructed disability as less important than other marginalized identities. Conversely, the disability support workers constructed disability as the most or even the only important identity, while seeming to lack an intersectional analysis altogether.

The sexual assault support workers' constructions were reflected in their service delivery as a lack of services targeted toward women who have a developmental disability—and disabled women, as a broader category. It was also reflected in the lack of self-criticism regarding their training and educational policies on developmental disability. The disability support workers' constructions were reflected in their service delivery as a lack of acknowledgement of the re-victimizing potential of their policies, and a lack of knowledge about the feminist support work model.

This thesis demonstrates that further work is necessary to ensure accessibility for women who have a developmental disability at sexual assault support organizations, and to educate disability support organizations about feminist responses to sexual assault, including the feminist support work model. This could be accomplished if the two types of organizations worked together, however, the gap between organizational philosophies would have to be bridged in order for this to occur.

Further research is required to evaluate feminist sexual assault support services for women who have a developmental disability, as well as disability support workers' approaches to working with women survivors of sexual assault. The exclusion of developmental disability from feminist research and activism, as well as the lack of consideration given to feminist approaches by developmental disability support workers, must continue to be examined. It is important to include women survivors who have a developmental disability as participants in future research projects, as their insights are required to accurately assess the delivery of services and to identify areas that they believe need improvement. If women survivors who have a developmental disability are not consulted, their lived experiences will not be acknowledged and they will continue to be marginalized within feminist research. It would also be beneficial to study Ontario disability support workers' attitudes and responses regarding the quality assurance measures, especially the mandatory reporting policy, in much greater detail.

This research contributes to the literature on feminist support work and services for women survivors of sexual assault who have a developmental disability, an area that has not been widely studied. Indeed, existing literature on sexual assault and developmental disability focuses on prevention and medicalized services for survivors, such as counselling, but largely omits any discussion of the feminist support work model (Hingsburger, 1993; Hollomotz, 2011; Mansell, Sobsey, Wilgosh & Zawallich, 1996; Schwier & Hingsburger, 2000; Shames, 2006; Sobsey, 1994). It is my hope that this research will be a starting point for further study and discussion of feminist support work for women survivors of sexual assault who have a developmental disability, and that sexual assault support workers and disability support workers alike will use these results to evaluate and improve their own service delivery. While there is a divide between the types of organizations interviewed, I believe that these workers can collaborate and find common ground, narrowing or even eliminating the divide, in order to improve services for survivors.

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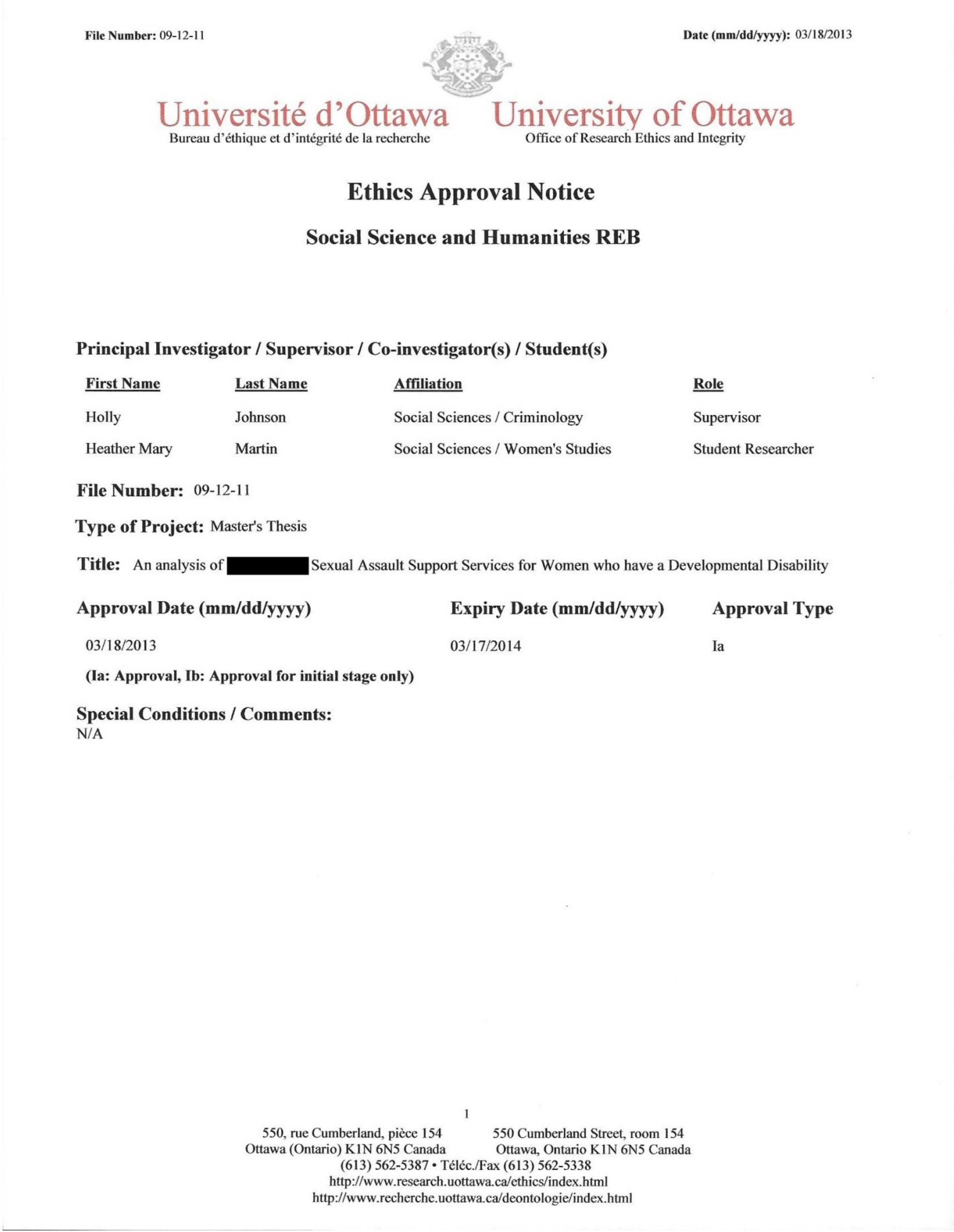
Appendix A—Research Ethics Board Approval



File Number: 09-12-11 **Date (mm/dd/yyyy):** 03/18/2013

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Social Science and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

First Name	Last Name	Affiliation	Role
Holly	Johnson	Social Sciences / Criminology	Supervisor
Heather Mary	Martin	Social Sciences / Women's Studies	Student Researcher

File Number: 09-12-11

Type of Project: Master's Thesis

Title: An analysis of [redacted] Sexual Assault Support Services for Women who have a Developmental Disability

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
03/18/2013	03/17/2014	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A

550, rue Cumberland, pièce 154
Ottawa (Ontario) K1N 6N5 Canada
550 Cumberland Street, room 154
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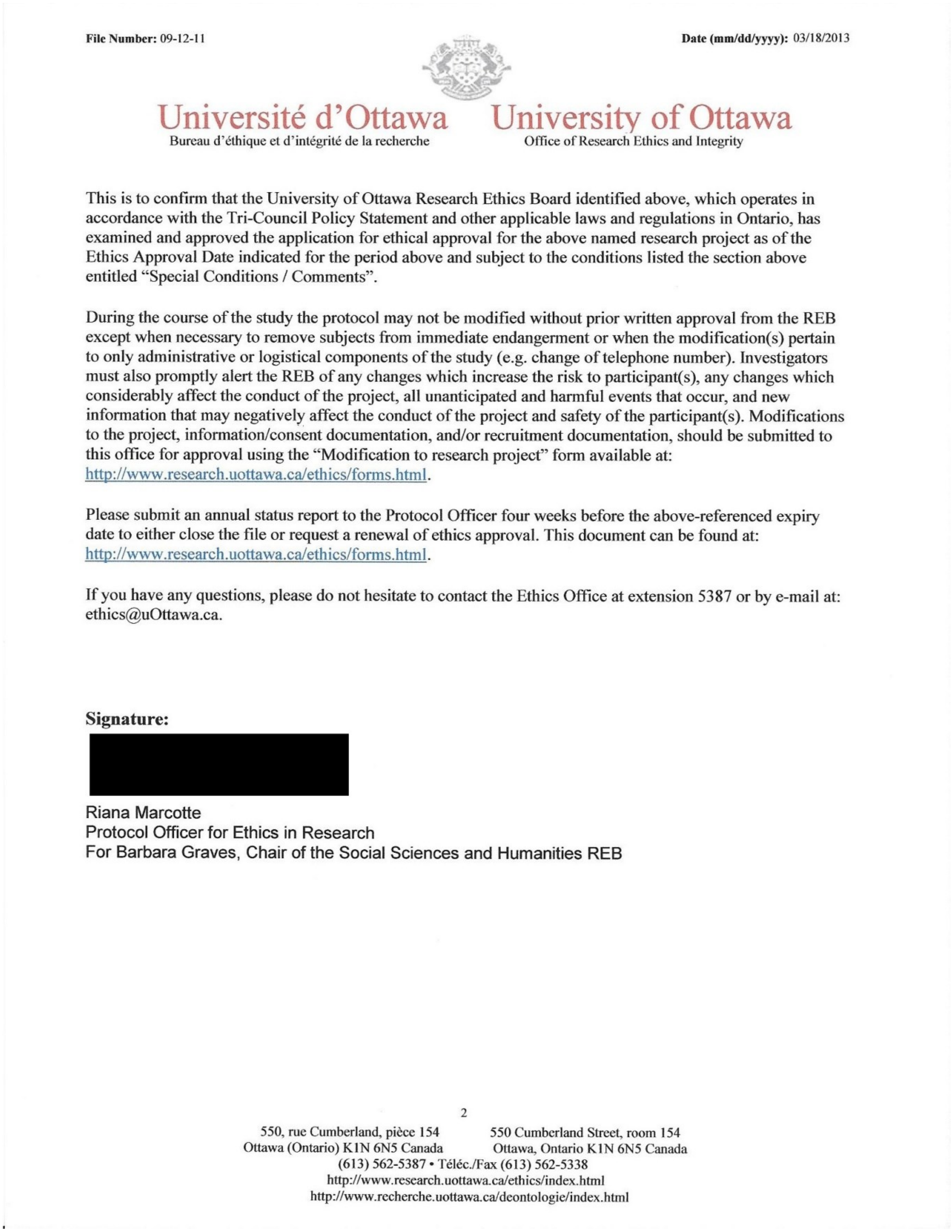
(613) 562-5387 • Téléc./Fax (613) 562-5338
http://www.research.uottawa.ca/ethics/index.html
http://www.recherche.uottawa.ca/deontologie/index.html



File Number: 09-12-11 **Date (mm/dd/yyyy):** 03/18/2013

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: http://www.research.uottawa.ca/ethics/forms.html.

Please submit an annual status report to the Protocol Officer four weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: http://www.research.uottawa.ca/ethics/forms.html.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

[redacted]

Riana Marcotte
Protocol Officer for Ethics in Research
For Barbara Graves, Chair of the Social Sciences and Humanities REB

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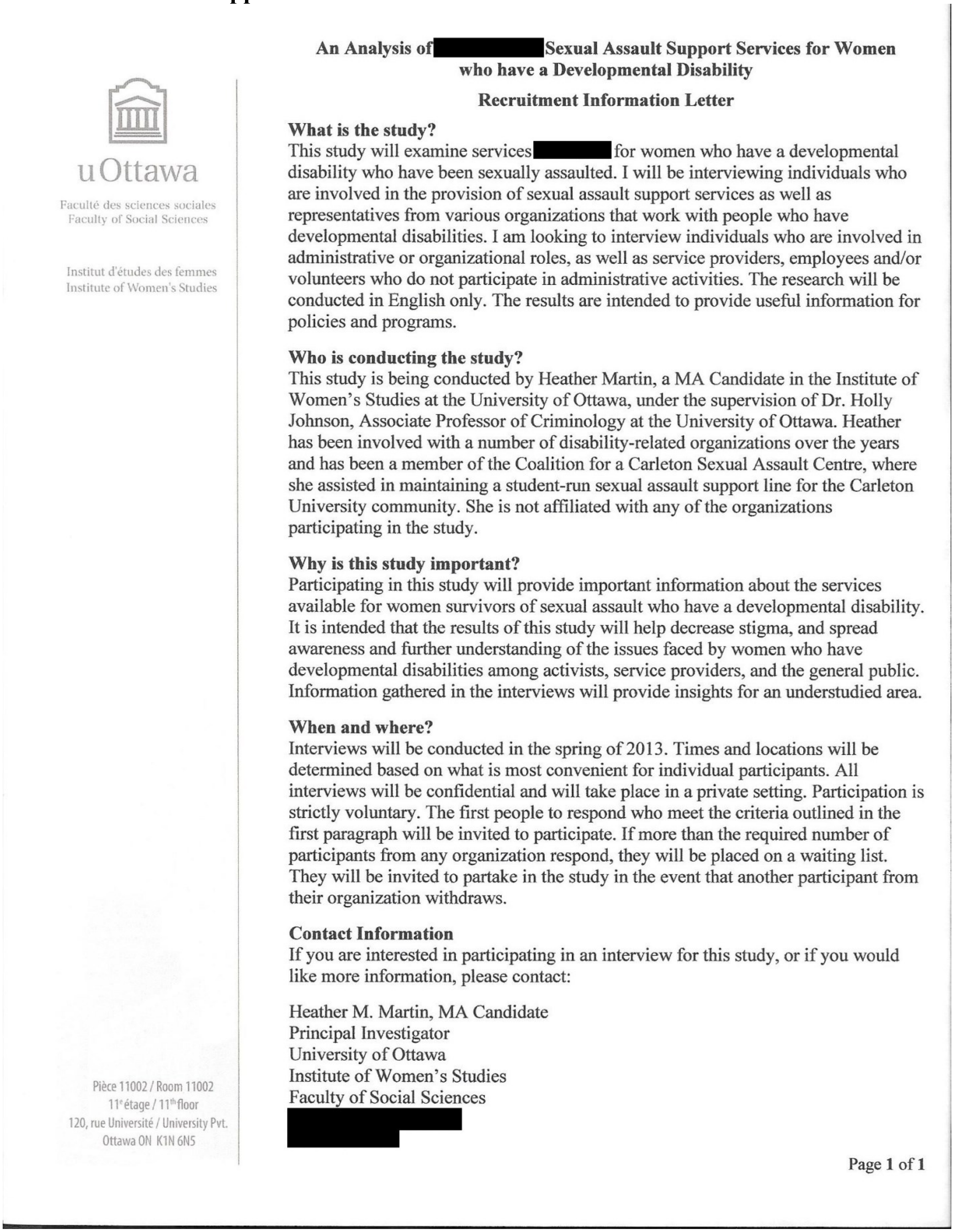
http://www.recherche.uottawa.ca/deontologie/index.html

Appendix B—Recruitment Information Letter



uOttawa

Faculté des sciences sociales
Faculty of Social Sciences

Institut d'études des femmes
Institute of Women's Studies

An Analysis of [redacted] Sexual Assault Support Services for Women who have a Developmental Disability

Recruitment Information Letter

What is the study?
This study will examine services [redacted] for women who have a developmental disability who have been sexually assaulted. I will be interviewing individuals who are involved in the provision of sexual assault support services as well as representatives from various organizations that work with people who have developmental disabilities. I am looking to interview individuals who are involved in administrative or organizational roles, as well as service providers, employees and/or volunteers who do not participate in administrative activities. The research will be conducted in English only. The results are intended to provide useful information for policies and programs.

Who is conducting the study?
This study is being conducted by Heather Martin, a MA Candidate in the Institute of Women's Studies at the University of Ottawa, under the supervision of Dr. Holly Johnson, Associate Professor of Criminology at the University of Ottawa. Heather has been involved with a number of disability-related organizations over the years and has been a member of the Coalition for a Carleton Sexual Assault Centre, where she assisted in maintaining a student-run sexual assault support line for the Carleton University community. She is not affiliated with any of the organizations participating in the study.

Why is this study important?
Participating in this study will provide important information about the services available for women survivors of sexual assault who have a developmental disability. It is intended that the results of this study will help decrease stigma, and spread awareness and further understanding of the issues faced by women who have developmental disabilities among activists, service providers, and the general public. Information gathered in the interviews will provide insights for an understudied area.

When and where?
Interviews will be conducted in the spring of 2013. Times and locations will be determined based on what is most convenient for individual participants. All interviews will be confidential and will take place in a private setting. Participation is strictly voluntary. The first people to respond who meet the criteria outlined in the first paragraph will be invited to participate. If more than the required number of participants from any organization respond, they will be placed on a waiting list. They will be invited to partake in the study in the event that another participant from their organization withdraws.

Contact Information
If you are interested in participating in an interview for this study, or if you would like more information, please contact:

Heather M. Martin, MA Candidate
Principal Investigator
University of Ottawa
Institute of Women's Studies
Faculty of Social Sciences
[redacted]

Pièce 11002 / Room 11002
11^{e} étage / 11th floor
120, rue Université / University Pvt.
Ottawa ON K1N 6N5

Page **1** of **1**

Appendix C—Interview Guide for Sexual Assault Service Providers

- What is your position with this organization? How long have you been working/volunteering for this organization?
- Please describe the various services your organization offers, and who they are available to.
- What different communities in your city do you work with, or work to accommodate?
    - Have you ever done any work with community groups who focus on developmental disabilities?
- How do you think a woman's experience of disability (and/or another part of their identity) might affect their experience of sexual assault?
- Have any women who have developmental disabilities accessed your services?
    - If yes, what can you tell me about this experience?
    - If no, do you think that a woman who has a developmental disability would access your services?
    - What obstacles might a woman who has a developmental disability face when trying to access your services?
        - Do you think these obstacles would be different depending on whether or not a person is racialized, if her/his first language is not English or French, if she/he identifies as queer or trans, or is living in poverty? Why or why not?
- Does your organization offer any services specifically targeted toward survivors who have a developmental disability?
    - If yes,
        - What are the services?
        - What has it been like to provide these services?
    - If no, has your organization offered any services like this in the past?
        - If yes, why are they no longer offered?
- Does your organization have any public education initiatives?
    - If yes,
        - What subjects do they address?
        - Have they ever addressed developmental disability?
            - If yes, what does that particular initiative entail?
            - If no, do you think that your organization would consider addressing developmental disability in the future?
- Do all members of your organization receive the same support worker training?
- What did your training involve?
    - What does your training discuss regarding disability (and other identities, e.g. racialized status, socioeconomic status, gender and sexual identity, religion)? What about developmental disabilities?
        - If the training does not discuss anything of this sort,
            - Do you think this type of training would be beneficial to you and others in your organization?
            - Do you think the members of your organization would be open to taking this type of training?

Appendix D—Interview Guide for Representatives of Organizations Serving People who have Developmental Disabilities

- What is your position with this organization? How long have you been working/volunteering for this organization?
- Are you (or have you ever been) a caregiver to someone who has a developmental disability?
- What can you tell me about who your service users are?
- What type of services or programming does your organization offer specifically for women who have a developmental disability?
- Do you liaise with any community groups in order to better suit the diverse needs of your members?
  - If yes, which groups?
- Does your organization have any policies surrounding sexual assault?
  - If yes, what are these policies?
  - If no, why do you think that your organization does not have these policies?
- Does your organization offer any training to members regarding sexual assault?
  - If yes,
    - What does this training entail, and how often is it held? What do participants think of it?
  - If no,
    - Has your organization offered anything like this in the past?
      - If yes, why is it no longer offered?
    - Do you think that your organization and its members would be open to having this type of training in the future?
- How do you think a woman's experience of disability (and/or another part of their identity) might affect her experience of sexual assault?
- If a woman who has a developmental disability disclosed to you that she had been sexually assaulted, what would you do?
- Are you familiar with the idea of sexual assault support services?
  - If yes (or somewhat/maybe),
    - Please explain what you know about sexual assault support services.
    - Which services are you aware of in this city?
    - Do you know where to look or who to ask to find information about these services?
    - What is your perception of these services?
    - Do you know what other members of your organization think about these services? If yes, what do they think?
    - Do you prefer one type of service over another? Why?
  - If no, what do you think support might entail?
- What obstacles do you think you might encounter when assisting a woman with accessing sexual assault support services?

    - Do you think these obstacles would be different depending on whether or not a person is racialized, if her/his first language is not English or French, if she/he identifies as queer or trans, or is living in poverty? Why or why not?
- Have you ever attempted to access sexual assault support services in this city for or with a woman who has a developmental disability?
    - If yes,
        - At the time, did you know where to look or who to ask to find information about these services?
        - What type(s) of service(s) did you attempt to access?
        - Were you able to access the services you needed?
            - If yes, were you satisfied with these services? Why or why not?
    - If no,
        - Do you know where to look or who to ask to find information about these services?

Appendix E—Informed Consent Form

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Faculty of Social Sciences

Institut d'études des femmes
Institute of Women's Studies

Pièce 11002 / Room 11002
11e étage / 11th floor
120, rue Université / University Pvt.
Ottawa ON K1N 6N5

Informed Consent Form

Title of the Study:
An Analysis of [redacted] Sexual Assault Support Services for Women who have a Developmental Disability

Researcher:	**Thesis Supervisor:**
Heather M. Martin, MA Candidate	Dr. Holly Johnson
University of Ottawa	University of Ottawa
Institute of Women's Studies	Department of Criminology
Faculty of Social Sciences	Faculty of Social Sciences
[redacted]	[redacted]

Invitation to Participate:
I am invited to participate in the abovementioned research study conducted by Heather Martin and supervised by Dr. Holly Johnson.

Purpose of the Study:
This study will examine services [redacted] for women who have a developmental disability who have been sexually assaulted. Both sexual assault centres and organizations serving people who have developmental disabilities are invited to participate. The results are intended to provide useful information for policies and programs.

Participation:
My participation will consist of a semi-structured, confidential interview with the researcher which will last approximately one hour. I will be asked about my knowledge of sexual assault support services for women who have a developmental disability, and about my personal experiences and professional training regarding this topic. The interview will not contain personal questions about direct experiences of sexual assault against me or anyone else.

Risks:
Participating in this study involves discussing my views and experiences and the policies of my organization. Discussing the topic of sexual assault may cause me to feel uncomfortable or experience emotional stress. I have been assured by the researcher that every effort will be made to minimize these risks and that I have the right to refuse to answer questions and/or withdraw my participation at any time without penalty. Ms. Martin has offered me a list of community resources that may help me to deal with this stress if I need them.

Benefits:
Participating in this study will provide important information about the services available for women survivors of sexual assault who have a developmental disability. The results of this study will be used to decrease stigma, spread awareness, and further understanding of the issues faced by

Page **1** of **3**

women who have developmental disabilities among activists, service providers, and the general public. Once the study has been completed, Ms. Martin will present me with a full copy of the report as well as an executive summary. She will present the same information to my organization and will offer to make a presentation to my organization detailing the findings.

Confidentiality and Anonymity:
The researcher has assured me that the information I share will remain strictly confidential and that any quotations from the interview will have any identifying information removed. I understand that the information I provide will be used only for research purposes and that my confidentiality and anonymity will be protected. This will be ensured through secure storage of the information I provide, the limited people who have access to the information (Ms. Martin and Dr. Johnson), and the fact that the interview is taking place in a private space with no recording devices other than the researcher's audio recorder.

Conservation of Data:
All data collected for this study will be secured in a locked filing cabinet for five (5) years following the completion of the research. The electronic data collected (including audio recordings of this interview, transcripts, and any notes or documentation arising from this interview) will be stored on a portable hard drive and the files will be protected by a password available only to Ms. Martin and Dr. Johnson. A copy of the data and documentation collected will be stored in an alarm protected office at the University of Ottawa.

Voluntary Participation:
I am not obligated to participate in this study and if I choose to participate, I have the right to withdraw from the study at any time and/or refuse to answer any questions, without suffering any penalty or negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

This interview will be recorded with an audio recorder in order for the researcher to obtain the most accurate information. The audio recording will remain strictly confidential and the recorder will be stored in a locked cabinet in the thesis supervisor's locked and alarm protected office at the University of Ottawa. If I do not consent to audio recording, the researcher will take notes on a laptop computer throughout my interview.

☐ I consent to having my interview audio recorded.

☐ I do not consent to having my interview audio recorded. The researcher will take notes on a laptop computer throughout my interview.

If I choose, I may review the transcript (written copy) of this interview and make changes to any of my comments and/or remove any comments. Transcripts will be password protected and sent via e-mail. I will receive a separate e-mail containing my password.

☐ I want to review the transcript (written copy) of this interview.

☐ I do not want to review the transcript (written copy) of this interview.

Acceptance:

I, ______________________________ (name) agree to participate in the above research study conducted by Heather Martin of the Institute of Women's Studies at the University of Ottawa, conducted under the supervision of Dr. Holly Johnson of the Department of Criminology at the University of Ottawa.

If I have any questions about this study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact:

Protocol Officer for Ethics in Research
University of Ottawa, Tabaret Hall
550 Cumberland Street, Room 154
Ottawa, ON K1N 6N5
Email: ethics@uottawa.ca
Telephone: 613-562-5387

There are two copies of this form; one for myself and one for the researcher.

Participant's signature: ___________________________

Date: ___________________

Researcher's signature: ___________________________

Date: ___________________