

Women's Health

Complexities and Differences

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The Last Sisters: *Health Issues of Women with Disabilities*

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Women with disabilities may sometimes have complex needs, but failure to acknowledge their commonalities and similarities with other women marginalizes and isolates women who are struggling to see themselves and wish others to see them as women, not as genderless beings. Carol Gill raises critical questions about how to meet the health needs of women whose place in the diversity of womankind has often been neglected.

The needs and concerns of women with disabilities are less exotic than many nondisabled people might imagine. In fact, the health issues that women with disabilities highlight as critical may sound unexpectedly familiar. They should sound familiar, because they are women's health issues.

When the women's movement attracted national notice almost three decades ago, many of us with disabilities embraced feminist ideology wholeheartedly. We had experienced not only women's unequal status but also the "special" unequal treatment society reserved for persons with disabilities. Our multiminority group membership impressed in every fiber of our being that destiny was not determined by biology. Shortly after joining the struggle for "women's liberation," many of us also joined the newborn struggle for "disability rights." As our consciousness grew from both involvements, we realized that most of the barriers we faced in life were not caused by our somatic differences any more than by our sex. The major problems we experienced were rooted in the way society responded to us—by the way we were socially devalued, excluded from the playing field as women, and rendered invisible both in the health service system and health reform movements.

Criticism of the women's movement regarding its middle-class, white, college-educated leadership is addressed by Ruzek, Olesen, and Clarke in chapter 3. Properly, many feminist organizers responded to charges of elitism and exclusion by reaching out to poor women, undereducated

women, women working in factories and in fields and in their own homes, women of all colors, and women in the third world. Increasingly over the past fifteen years, all have been invited to join the sisterhood. In recent years, however, the movement has encountered a fresh challenge: Women with disabilities have added a new element to the conscience and consciousness of the women's movement. We have pointed out its ableism. We have complained about meetings held in inaccessible locations with no alternative formats for blind and deaf women. We have protested our omission from agendas purporting to cover women's concerns. We have called for a recognition of our sociopolitical issues and perspective. We have been uniting to write and speak to let other women know that we are here, we are women, and we are sisters.

A striking article appeared in *Ms.* magazine in 1992 written by Bonnie Klein, a Canadian who acquired a disability after establishing a prominent place in the women's movement. As the permanent effects of her stroke became apparent, she found herself treated as an outsider at feminist gatherings—as if she no longer had women's issues. Her article in *Ms.* described her process of connecting with other disabled women activists and her successful efforts to remain included in feminist circles. Her message to her sisters, used as the title of her article, was "We Are Who You Are."

Paralleling Klein's analysis, the message of this chapter is this: "Our health issues are your health issues." As women, we share many major areas of health concern with other women. In many cases, our health service needs are identical to those of any woman. Problems arise not inherently from our disabilities but from socially constructed barriers—such as stairways and small print—that impede our access to services. As a minority group of women, however, some of our health issues have a different emphasis or intensity. Thus some of our needs may be similar, but services must be adapted to the complexities of our disabilities. For example, a woman with a cognitive disability may need contraceptive instructions translated into simpler language. A physically disabled woman might need more time for an exam to accommodate her arduous transfers from wheelchair to examination table. Further, like women in other minority or multiminority communities (e.g., lesbians, African Americans), we sometimes experience "unique" health service needs deriving in two ways from our group membership: (1) needs determined by actual physiological and inherently related lifestyle differences, and (2) those determined by the distinct character of our social oppression.

The reluctance and sometimes outright resistance we have encountered from nondisabled feminists in acknowledging us as part of the

sisterhood have been painful, but matters are improving. Particularly frustrating, because it remains incompletely resolved, is our lack of recognition as a social minority group. Many in the women's movement believe, when confronted by our presence, that we deserve inclusion as women and girls "with special needs." However, acknowledgment of our issues as sociopolitical and of our community as a positive and viable component of women's diversity has lagged behind. Yet until the social origin of our marginalization is appreciated as readily as it is for other minority women's communities—until the vile impact of ableism is understood on par with all the other "isms"—our issues, including our health issues, will remain muddled and we will remain unequal within the movement for women's equality. We will be viewed as damaged women instead of women who, like others, are unfairly stereotyped, excluded, and restricted on the flimsy pretext of biology.

A clear sense of disability as a sociopolitical status, then, is the crucial foundation to understanding the health issues of women with disabilities. Because the general economic, social, cultural, and political realities of disabled women's lives have already been well covered (for example, in Fine and Asch's invaluable 1988 text, *Women with Disabilities*), they will not be taken up here. Emphasis will be placed, instead, on clarifying the interface between physiology and social/policy factors in disabled women's health needs. The relation of those needs to the health needs of non-disabled women will also be explored.

At times, we have been treated in health service settings as if our disabilities set us apart from other women when they did not. Conversely, we have sometimes been treated as if our needs were not different from average when they were. Both types of error are trouble for us. To be effective and responsive, our health service providers must know more about exactly how our experiences fit into existing knowledge and planned research on women's health.

Any authentic discussion of health issues affecting women with disabilities will reveal two leitmotives that surface repeatedly to link seemingly disparate topics. One theme is *invisibility*. Women with disabilities have been working hard to emerge from decades of neglect in medical services and research, including programs expressly designed to encompass the diversity of all women's health needs. The second theme is *genderlessness*. When we tell each other our stories, we inevitably exchange complaints of feeling treated not as women at all but as some kind of neutral

gender or nonsexual being. Feeling invisible and feeling genderless go hand in hand. If society or the medical system or even our own sisters in the women's movement fail to recognize our womanness, we remain invisible when women's health issues are researched—for example, in studies of pregnancy, contraception, menopause, and sexual abuse.

In the 1990s, we launched a health initiative of our own, organizing across the United States and sometimes internationally. To halt our invisibility and degenderization, we have been publishing, presenting at conferences, developing service, resource, and education programs, and researching our health issues at an unprecedented rate. We are taking the reins in defining our needs, guaranteeing our options, in short, making ourselves hard to ignore. The remainder of this chapter summarizes our efforts.

Access

Women with disabilities share with all women a history of exclusion from health services and research that have traditionally been open to men. Moreover, many disabled women belong to additional disenfranchised groups, serving to undermine further their access to health programs that may benefit them.

Gender Inequity

In health care access, women with disabilities encounter all the problems other women do and then some. We experience the "double whammy" of discrimination as women and discrimination as disabled people, and often that discrimination adds up to more than the sum of its parts. If we hold membership in racial/cultural minorities, have a devalued sexual identity, are old, or are experiencing the poverty that often comes with disability, the resulting oppression escalates. We have had much less attention focused on our health needs compared with men within the specialty of rehabilitation medicine. Historically, medical rehabilitation has focused on the needs of men: soldiers returning from war with injuries; workers who have accidents and need therapy to regain their status as breadwinners; athletes who go down in agony while pursuing the thrill of

victory. These have been the clients whom rehabilitation was developed to serve.

Until the last decade, most rehabilitation research, medical and psychological, involved only male subjects. Men dominated studies of organ system functioning in the presence of various disabilities, sexuality, vocational and economic outcome, marital adjustment, depression, and even relationships with children. Women with disabilities have a lot of catching up to do. Like nondisabled women, we reject having our medical needs estimated on the basis of data collected exclusively on men. We must achieve parity with disabled men in access to rehabilitation medicine research and services. Concurrently, we must ensure that women with disabilities are not left out of national research studies focusing on the health needs of women in general. Again, we seek visibility as minority women and inclusion as women.

Service Barriers

Like all women, we want equal access to community health services—to preventive services and treatment. Here, many of our issues are similar if not virtually identical to those of other women. Poverty, loss of insurance, lack of health information, and lack of transportation often keep us from getting to health service facilities at all. Two-thirds of persons with disabilities who wish to work are still denied jobs, and disabled women historically earn significantly less than either disabled men or nondisabled women. Women of color with disabilities earn even less money, and aging women with disabilities often experience increasing social isolation and loss of support for meeting their health needs (Fine and Asch 1988). Thus access obstacles may be more intense and demoralizing for us than for most women.

Women with disabilities must contend with an additional array of barriers unique to the experience of disability in this culture. Man-made physical impediments such as stairs and narrow doorways keep us from entering facilities once we find them. Programmatic barriers are a problem, too, such as scheduling that does not permit us the extra time we need to move or communicate or understand, or not having people on staff who can assist us onto examining tables or who know how to adjust equipment such as mammography machines to accommodate our different sizes and postures. The absence of teletypewriters (TTY), sign language

interpreters, and information in Braille or in audiotaped form excludes full and equal utilization of services by deaf or blind women. Most structural and programmatic barriers are addressed in the 1990 Americans with Disabilities Act (ADA), which mandates the removal of discriminatory barriers in buildings, the workplace, communication systems, and transportation. Increasingly, women with disabilities are learning to use the ADA to construct fully accessible health service programs and to counter exclusion in existing programs.

How many women with disabilities are stopped from getting routine physical exams and other health services by remediable physical and programmatic barriers, poverty, lack of insurance, lack of transportation, and discriminatory attitudes in the health service system? It is impossible to know because there is virtually no systematic research documenting the health service experiences of women with disabilities. Baseline information is just starting to be collected about what kinds of health services we are getting, what kinds we are not getting, where we are getting our services, and where we would prefer getting them. I am directing such an investigation through the Health Resource Center for Women with Disabilities in Chicago.¹ Much of this basic fact-finding is being led by researchers and program directors who are, themselves, women with disabilities.

Invalidation of Sexuality and Reproductive Health

In the area of sexuality and reproductive health, as is true for our nondisabled sisters, ensuring our reproductive rights and options has been a long struggle. Unlike nondisabled women, who emphasize the right to delay or bypass having children, we are still fighting for the right to become mothers at all. Society generally invalidates disabled women's sexuality. If anything, our reproductive potential is feared. We are presumed either incapable of producing the kind of babies society wants—healthy babies—or incapable of adequately nurturing children.

Women with disabilities share with nondisabled women a tradition of restricted health service options and society's efforts to control our bodies. For most women, such external control is directed toward ensuring the birth of the next generation and satisfying the sexual and domestic needs of men. For disabled women, whose procreative and aesthetic functions

are both devalued, the dynamics of social control are somewhat different. By casting us in the stereotypes of the perpetual asexual child or dried up crone, society justifies its invasive custody over women with disabilities and the prevention of our fertility.

We have endured a long history of medical treatment without consent, including involuntary and concealed contraception, sterilization, and abortion. We are routinely denied critical information regarding our bodies and treatment options while being subjected to unexplained procedures and medications approved by family members, judges, and professionals. Women with disabilities who are either very young or very old, who lack social support, who are impoverished, or who have communication or cognitive disabilities are most likely to be treated in this manner. This kind of thinking has been the basis of a long history of forced sterilization for women with disabilities. It has also been one of the reasons we have so little empirical knowledge of disabled women's reproductive health.

In research, our status parallels that of nondisabled women who are past their reproductive years. Stereotyped as nonbreeders, we are not even considered in reproductive research agendas. Although we are the ones who have the babies, there has been more research on the fertility and sexuality of disabled men than disabled women!

Right now, we know enough about our reproductive health issues to know that we need to know more. We need more scientific information about hormone system functioning in the presence of different disabilities, fertility and contraception, and parenting. We know, for example, that women with some mobility disabilities are likely to have more bone loss at an earlier age than nondisabled women. But how do treatments for osteoporosis affect us? Is calcium supplementation safe for our kidneys if our fluid intake and elimination patterns are affected by disability? Is estrogen replacement safe for women of limited mobility with compromised circulation in the legs? How do specific disabilities interact with contraceptives and with pregnancy? There is anecdotal evidence that pregnancy can be good for certain disabilities, such as arthritis. On the other hand, we know that traditional birthing methods can put some women with disabilities at high risk unnecessarily. For example, some women with spinal cord injuries have died needlessly because their physicians failed to realize that labor contractions can provoke dysreflexia, spiking their blood pressure to levels causing strokes (Verduyn 1994).

Some promising studies are emerging regarding sexuality and repro-

ductive health issues of women with disabilities. Beverly Whipple and her colleagues are studying the sexual response cycle in women with spinal cord injuries (Whipple and Komisaruk 1993). At the Rehabilitation Institute of Chicago, several physicians are examining the interaction between disability and treatment for osteoporosis in menopausal and postmenopausal physically disabled women.

There are also some studies planned on contraception. Women with disabilities need much more information on how available contraceptives affect us. We also want better methods developed—ones that leave us more in control and less reliant on physicians than the injectable and implanted contraceptives commonly administered to women with disabilities. A recent study of high school girls with disabilities revealed an unexpected and alarmingly high rate of unplanned pregnancies in learning disabled teenagers (Wagner et al. 1992). Such results underscore the need for more research on how disabled girls learn about sex and conception as well as how we can provide them with better information. For too long it has been assumed that disabled women cannot manage contraception. It is imperative that we learn *how* to manage the most effective contraception for us, if that is what we want, and how best to have children, if that is what we want.

Women with disabilities are, in fact, losing custody of their children because they are presumed to be incapable parents. Only one organization, Through the Looking Glass in Berkeley, California, has actually formulated and implemented substantial research on the relationship between disabled persons and their children (Kirshbaum 1988). What they found over the past decade refutes all the stereotypes. Not only can disabled women mother in a variety of creative ways, but research shows that our children accept and cooperate with our parenting styles in ways that may, in fact, enhance the mother-child relationship and the development of the child. For example, babies may benefit when mothers who move slowly spend extra time on child-care tasks. Such children learn to coordinate in a matter-of-fact manner with parents who function differently, encouraging their later acceptance of human differences.

Abuse

Perhaps the most striking and dangerous example of disabled women's invisibility is in the area of abuse prevention, intervention, and research.

Privacy

Like nondisabled women, many of us are victims of assault by partners, relatives, dates, casual acquaintances, service providers, and strangers. Yet we are rarely included in research and service programs that deal with sexual, physical, or emotional abuse of women. I have encountered a shocking level of naïveté on this matter in day-to-day interactions with both women's protection advocates and disability service providers. As one incredulous rehabilitation specialist asked when told of an assault against a woman wheelchair user, "Does this kind of thing really happen?"

We need much more research on violence as a factor in disabled women's lives, including attention to the interaction of disability type, race, and age in mediating risk. From what women with disabilities report, we are at high risk at all ages. In fact, the limited research and anecdotal evidence that address abuse in women with disabilities suggest that our chances of being assaulted may be twice those of nondisabled women. The perpetrators are often the persons we rely on for daily assistance in living, including family members, spouses, and hired personal assistants. According to Margaret Nosek (1995), many disabled women report being abused by professionals in medical settings. The sexual assault of disabled women in residential or educational institutions, including nursing homes and group homes for persons with cognitive or emotional disabilities, is more the rule than the exception. Some studies have indicated that more than 90 percent of all women with disabilities will experience abuse in the course of their lives (Pelka 1993). In Canada, Dick Sobsey (1994) and the DisAbled Women's Network² have been collecting important data on assault, but we need more.

In the meantime, the facts are strong enough to demand greater attention to women with disabilities in services and programs for violated women. We must be more widely acknowledged as a defined minority when assault reports are filed. Our statements about the abuse we have experienced must be respected and believed. When we are unable to report our experiences because of fear or disability-related communication difficulties, the possibility that we have been victimized must be considered by health service providers. Women with disabilities who advocate for peers who have been assaulted, such as Veronica Robinson of Access Living,³ say that most shelters are still inaccessible and unaccommodating to women with mobility, sensory, and cognitive disabilities. The sad truth is that many women with disabilities are forced to stay in dangerous situations because they have been excluded from the safe places other women have provided for each other.

Safeguarding our privacy against both offhanded and deliberate violation requires continual vigilance and assertiveness. Most women with disabilities can recount disturbing experiences of medical exams performed with doors or curtains left ajar, information about our private lives carelessly discussed in public places, or authorities monitoring and reporting our sexual behavior. Another form of violation so pervasive and traumatic to us that we have labeled it and categorized it as abuse is "public stripping": the practice of being forced to disrobe and display our different-looking bodies in medical educational settings (Blumberg 1990), often before mixed audiences of professionals and nonprofessionals or photographers. For example, in a 1993 telecast of a popular prime-time "news magazine" show, *NBC Now*, a physician pulled up the T-shirt of a twelve-year-old girl with cerebral palsy and, without even speaking to her, displayed her scoliotic back to a national television audience.

In writing and speaking openly about these violations, women with disabilities have been giving each other validation of our outrage and the courage to oppose further disrespect. Many of us have committed our efforts to educating health professionals and family members of women and girls with disabilities about our rights to privacy, information, and choice in medical settings.

Medical Negligence

All women have long been victims of systemic medical negligence, in that our needs have remained poorly researched and our access to adequate services has been inconsistent. Like other women, women with disabilities often feel that, compared with men, their complaints and questions are taken less seriously by physicians. Devalued populations are also vulnerable to additional forms of medical negligence. For example, physicians' tendency to view disabled women as asexual can result in failure to investigate signs of serious conditions, including cancer, pelvic disorders, sexual dysfunction, and sexually transmitted diseases. Women with disabilities also commonly express the conviction that they are dehumanized or objectified in medical settings—viewed exclusively in terms of their disabilities, not as total persons or women.

I know physicians who have openly admitted their discomfort in

responding to disabled women's complaints, particularly those involving the reproductive system, because they felt overwhelmed by the disability and saw the other possible health problems as secondary in importance or as unwelcome complications. Such professionals seemed disturbed by the idea that reproductive health or sexuality would be "significant" to their disabled patients. They prejudged childbearing to be beyond consideration for women with extensive disabilities.

Disabled women commonly complain that their health service providers evade questions about sexuality or body image. They report that their questions about subjects such as orgasm, pain during sex, the advisability of getting pregnant, childbirth, breast size, cosmetic flaws, and weight gain are often brushed off. This can be devastating to women who are already conditioned by society to feel unattractive and invalid as women.

Mental Health

The mental health needs of women with disabilities have received little research attention. There is no reason to believe, however, that having a disability would in any way immunize a woman against depression or other mental illness. In fact, if stress, social isolation, devaluation, and being deprived of meaningful roles contribute to emotional problems in women, as many experts believe, women with disabilities should be considered a group at particular risk.

Stress

According to those who experience it, being female and disabled is one of the most stressful statuses to which you can aspire. Being a woman of color or being a lesbian with a disability may compound the stress. A huge proportion of disabled women are poor and dealing with life without a partner. Each day, such women must deal with access issues, transportation problems, unmet health needs, negative messages about their attractiveness and validity as women, job discrimination, and unfair welfare policies that threaten to reduce even further their paltry resources.

Depression and Suicide

Depression shows up in women in the general population about twice as often as in men. A recent study completed by DAWN in Canada

revealed that almost two-thirds of their sample of 391 women with disabilities had considered suicide, and almost one-third of those had attempted it (Masuda 1994). Some observers relate disabled women's despair to social devaluation, our high incidence of abuse, and the fact that society largely prevents us from stepping into the desired roles of mother, partner, and worker. Yet we are often hard pressed to locate accessible, affordable mental health services or professionals who understand our issues.

We may not even receive suicide prevention services. Society seems increasingly willing to sanction the deaths of some disabled women who despair. For example, Jack Kevorkian's first eight "clients" were all middle-aged and elderly women with chronic disabilities or illnesses. Some feminists with disabilities are concerned that women with chronic conditions are becoming easier to discard just as the cost of health care coverage for "incurables" is being debated nationally. The National Organization for Women in several states has endorsed physician-assisted suicide measures. Such endorsements, spearheaded by women who view assistance in dying as a personal choice issue, do not reflect the views of disabled feminists who fear such measures will further oppress and endanger women whom society already views as defective and expendable.

It is imperative that women with disabilities and incurable conditions are included in research on depression, suicide, and other emotional problems. We also must be guaranteed adequate intervention and support when we despair. To be singled out as a group deserving of a hastened exit from life before our needs are adequately understood and our life choices are guaranteed may be the ultimate act of violence against women.

Policy

The new wave of health activism among disabled women includes opposition to public policies that reinforce our invisibility and degenderization. Many of us serve on committees or join disability rights demonstrations to fight for employment equity, accessible transportation, and universal design in the built environment. Unless discrimination is defeated in these areas, many of us will remain segregated—literally invisible in the mainstream—and powerless to achieve self-determination in other aspects of life.

Because a significant proportion of women with disabilities are unmarried and unemployed, many support the idea of universal single-payer

insurance that would not be based on employment status and would not exclude "preexisting conditions" or deny expensive disability-related equipment. We generally oppose any plan that would permit capitation or rationing of coverage based on "quality of life" measures or the "irreversibility" of medical conditions, as these criteria too easily can be used to justify withholding benefits from persons with disabilities.

Disabled women activists also publicly denounce policies that undermine or directly oppose our entitlement as women to have children and form families of our own choosing. For example, we fought for the right of Sharon Kowalski, a lesbian disabled in an accident, to live with and have her health services monitored by her chosen lover (Thompson and Andrzejewski 1988). We oppose state policies that wrest custody of babies from impoverished mothers with disabilities, such as Tiffany Callo, who cannot afford private child-care assistance (Mathews 1992).

For many women with disabilities, the availability of a part-time or full-time personal assistant is the deciding factor in whether or not we are able to live in our own homes, raise families, or go to work. The availability of such assistance is capricious, depending on the "in-home care" policy in that person's place of residence, because each state is allowed to set its own rules for the use of federal funds. In many states, in-home assistance is given low priority and citizens with disabilities must have extraordinary information and stamina to fight the bureaucracy to qualify. Consequently, thousands of men, women, and children with disabilities who could live in their own homes with reasonable assistance are incarcerated as "patients" in nursing homes for which the government pays many times what in-home personal assistance would cost. Disability activists across the country are demanding a national personal assistance policy that would divert funds now supporting the profitable nursing home industry into consumer-managed assistance programs that promote independence and dignity.

In some states, even if a woman qualifies for personal assistance funding, she may be penalized by policies that exclude child-rearing as an "activity of daily living" for people with disabilities. Many states pay someone to assist a disabled person with bathing, dressing, driving, food preparation, house cleaning, and even gardening, but strictly forbid the paid assistant from warming a baby's bottle or helping the mother position her infant for breast-feeding. Disabled women across the country have denounced such policies as punitive and disrespectful of our right to parent as well as invasive of the private working relationship between per-

sonal assistants and the disabled persons who hire them. Such policies have caused women with disabilities who are impoverished by job discrimination and lack of spousal support to lose custody of their children.

Federal funding policies exact an impossible price from women with disabilities who wish to have full lives and health coverage, too. Barbara Faye Waxman, a colleague who has developed an ingenious program to enable disabled women to gain access to federally funded family planning services,⁴ now faces a profound violation of her own right to form a family. She is engaged and wants to marry. Disabled since birth, she uses a power wheelchair and ventilator as well as a full-time personal assistant, all expensive goods and services in our current health system. If she remains single, Social Security disability payments will cover her disability-related expenses. If she marries, however, her husband's income will be considered hers, negating her eligibility for government assistance. Without this assistance, her husband's entire salary will be swallowed by her disability-related expenses, and their new marriage will be subjected to the torture test of instant poverty. As she put it, "I searched until I was 39 years old for both a job that would utilize my worldview and the right man to love me. Now Social Security policies are forcing me to give up one of them if I want to move and breathe!"

We need more research on the way women with disabilities are affected by public policies. We also need more support for programs that are attempting to apply nondiscrimination laws, such as the Americans with Disabilities Act, to secure our rights to accessible health services, protection from abuse, mental health support, family planning, and dignified personal assistance in our own homes.

Gaining Visibility as Women's Health Activists

Our recent efforts to organize around health issues have helped women with disabilities become more visible to each other. This energizing process has revitalized our determination to be included in the women's movement and women's health agenda. We want research and services that acknowledge the complexity of our lives—that acknowledge the sociopolitical reality of disability in our culture rather than merely viewing us through a disease model—but that affirm our membership in the community of all women. We expect to continue exploring and addressing the needs of our minority community in our mentoring programs, health

advocacy and resource projects, professional training, and research. This will not, however, impede our intention to take our rightful place in the community of all women as we collectively work for the quality and inclusiveness of health services we deserve.

Increasingly, we realize and want others in the women's movement to realize that by asserting our health needs as a minority community, we are adding to a store of information that benefits all women. Here, diversity is at its paradoxical best. The experience of women with disabilities is set off as "different" when we focus on the particular constellation of variables that determine our health needs. But while the constellation itself may be our signature, the variables composing it—physiological, social, psychological, cultural, political, economic—link us inevitably and inextricably to other women. The experience of women with disabilities, when added to the experiences of other women, then, bring all of us an increment closer to understanding how these forces affect our health and our lives. The added benefit of our inclusion is that together we are all the more powerful in pushing forward our agenda for better and more inclusive policies and services for all women.

NOTES

1. For more information on this research contact Carol J. Gill, Ph.D., Chicago Institute of Disability Research, 7223 S. Kingery #225, Willowbrook, IL 60521.
2. DAWN CANADA: DisAbled Women's Network Canada is an organization of and for women with disabilities that carries out advocacy, research, education, and related services. They can be contacted at 776 East Georgia Street, Vancouver, BC V6A 2A3 CANADA.
3. Veronica Robinson is the deaf services coordinator for the domestic violence program at Access Living, 310 S. Peoria, Suite 201, Chicago, IL 60607.
4. Barbara Faye Waxman is the creator and director of the Americans with Disabilities Act and Reproductive Health Project through the Family Planning Council in California.

REFERENCES

- Blumberg, Lisa
 1990 "Public stripping." *Disability Rag* 11:18-20.
- Fine, Michelle, and Adrienne Asch, eds.
 1988 *Women with Disabilities: Essays in Psychology, Culture, and Politics*. Philadelphia: Temple University Press.

- Kirshbaum, Megan
 1988 "Parents with physical disabilities and their babies." *Zero to Three* 8:8-15.
- Klein, Bonnie S.
 1992 "We are who you are: feminism and disability." *Ms.*, March, 70-74.
- Masuda, Shirley
 1994 Personal communication.
- Mathews, Jay
 1992 *A Mother's Touch: The Tiffany Callo Story*. New York: Holt, Rinehart and Winston.
- NBC Television
 1993 "Do Not Resuscitate." *NBC Now*, televised 1 December.
- Nosek, Margaret A.
 1995 "Sexual abuse of women with physical disabilities." Pp. 487-502 in Trilok N. Monga (ed.), *Sexuality and Disability*. Philadelphia: Hanley Belfus.
- Pelka, F.
 1993 "Rape." *Mainstream* 18:24-33.
- Sobsey, Dick
 1994 *Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance?* Baltimore: Brookes.
- Thompson, Karen, and Julie Andrzejewski
 1988 *Why Can't Sharon Kowalski Come Home?* San Francisco: Spinsters/Aunt Lute.
- Verduyn, Walter H.
 1994 "A deadly combination: induction of labor with Oxytocin/Pitocin in spinal cord-injured women, T6 and above." Unpublished manuscript. Presented at the Conference on the Health of Women with Disabilities, National Institutes of Health, Bethesda, May.
- Wagner, Mary, Ronald D'Amico, Camille Marder, Lynn Newman, and Jose Blackorby
 1992 "What happens next? Trends in postschool outcomes of youth with disabilities. The second comprehensive report from the national longitudinal transition study of special education students." Office of Special Education Programs, U.S. Department of Education.
- Whipple, Beverly, and Barry R. Komisaruk
 1993 "Current research trends in spinal cord injuries." Pp. 197-207 in Florence P. Haseltine, Sandra S. Cole, and David B. Gray (eds.), *Reproductive Issues for Persons with Physical Disabilities*. Baltimore: Brookes.