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Occupational Therapy's Role with Victims of Domestic Violence

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PART II

Occupational Therapy's Role with Victims of Domestic Violence: Assessment and Intervention

Christine A. Helfrich, PhD, OTR/L
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SUMMARY. Occupational therapists encounter individuals who are victims of domestic violence in many different settings. The role of the occupational therapist with each client depends on that client's specific needs, the treatment setting, and the skills and beliefs of the therapist. This article presents a theoretical argument for why the occupational therapist should choose to be involved in the treatment of domestic violence. The Model of Human Occupation provides a framework for understanding functional issues related to domestic violence. Methods of assessment and treatment are presented using this model. A continuum

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of levels of involvement including referrals for resources or treatment, direct and indirect treatment and program consultation is offered. Each level is illustrated with case vignettes demonstrating the therapist’s role. Issues related to the challenge of working in domestic violence and reasons that women may refuse intervention are also discussed. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com> © 2001 by The Haworth Press, Inc. All rights reserved.]

**KEYWORDS.** Domestic violence, model of human occupation, assessment

**INTRODUCTION**

Occupational therapists work with victims of domestic violence in every setting in which they are employed. The occupational therapist may not always be aware that the client with whom she or he is working is also a victim of domestic violence. The likelihood that the client is or has experienced domestic violence is increased if the person has a disability. Being abused and having a disability is a double disadvantage for women. Their disability may prevent them from leaving abusive situations or their partners may inflict injury resulting in disability (McNamara & Brooker, 2000). In other words, the women may have had preexisting disabilities not caused by the abuser or they may have disabilities as a result of the abuse. According to the National Crime Victimization Survey, approximately three-fourths of all violent events (e.g., rapes and assaults) involve an intimate or relative (U.S. Dept. of Justice, 1994).

Persons who experience domestic violence and disability encounter difficulties related to their disability (e.g., physical and/or mental limitations), and issues associated with domestic violence such as problems of poverty and economic dependence. These characteristics (e.g., physical limitations, economic dependence) often force women to remain in abusive relationships. Further, the safety of these women is most threatened when they attempt to leave their abusive situations (Holtz & Furniss, 1993). This places women in the predicament of relying on their abuser to survive, while jeopardizing their physical and/or emotional well-being. This combination of characteristics asso-
Associated with domestic violence and disability comprises a population in need of specific services.

While in abusive relationships, battered women rarely have the resources needed to live on their own and are often financially controlled and isolated by their batterers (Brandwein, 1999). A barrier to obtaining more personal independence for many women who are victims of domestic violence is a poor work history. Women who are able to work outside the home often have poor attendance due to injuries and stress (Brandwein, 1999). In addition, they may be required to give their paycheck directly to their abuser who controls the finances. Thus, women who seek services geared toward creating more personal independence may increase their risk for further harm and/or further disability.

Financial issues are critical in a woman’s decision to leave her abuser and whether she can become independent from him. It is also apparent that the pervasiveness of low-wage jobs limits the financial freedom that may prevent women from becoming homeless once they leave their abuser (Brandwein, 1999; Williams, 1998; Mullins, 1993). Because domestic violence shelters are often full and homeless shelters are reluctant to take victims of domestic violence, often the only choices for women are living on the streets or remaining with the abuser (Mullins, 1994). In New York City, after being sheltered, 31% of battered women returned to their batterers because they could not find low-income housing (Mullins, 1994). Emergency housing and support services for battered women may be the only real protection that society has to offer (Mullins, 1994). Shelters and other refuges for victims of domestic violence are ideal environments to address the skills that can prevent a woman from becoming homeless.

In addition to basic, traditional work skills, women often lack the life skills that are required to maintain a job and live independently (Helfrich, 1997). Women and the staff who worked with them in a transitional housing program identified difficulties with basic skills in budgeting, parenting, home management, stress management, anger management and other instrumental activities of daily living. However, there is little literature available that identifies or addresses the life skills required for victims of domestic violence to avoid becoming homeless. Occupational therapy has the potential to miti-
gate some of the life skill limitations that contribute to women becoming homeless.

In order for occupational therapists to assume their role with victims of domestic violence, the profession must begin to provide education and training regarding domestic violence. One of the primary reasons that occupational therapists do not address abuse with their clients is that they may not feel competent to do so (Johnston, Adams & Helfrich, 2001). How the therapist responds to a disclosure of domestic abuse has legal, ethical and practical implications. It is important for therapists to understand these implications in order to feel comfortable and competent. There are several levels on which to respond to the knowledge that a patient or client is a victim of domestic abuse, which range from providing referrals to other professionals to direct treatment of the abused woman.

The Cycle of Violence

In order to effectively evaluate an individual and respond to the results of that evaluation, the therapist must understand the range of experiences women have with their abusive partners. Lenore Walker (1979), in her classic text *The Battered Woman*, discusses this range of experiences as the Cycle of Violence. The Cycle of Violence has three phases.

- **Phase 1: Tension Building.** During this phase there is arguing, blaming, and tension in the relationship.
- **Phase 2: Battering.** This is the phase where the violence actually occurs. The violence may include physical violence such as slapping, choking, kicking, use of weapons, sexual abuse, and verbal threats and abuse.
- **Phase 3: Contrition.** This is the calm period after the abuse where the abuser denies the violence, apologizes, provides gifts or special treatment to the victim, and promises the abuse will not occur again.

This cycle represents a pattern of behavior that repeats itself. Each phase repeats, changing in relevant emphasis and severity over time. The Battering Phase will occur more frequently and the Phase of Contrition will be of shorter duration. In other words, as time goes on the battering increases in severity and occurs more frequently. The
other phases may still occur but will lose their emphasis in the life of the relationship. This is why intervention with victims of domestic violence must occur. If the cycle is not interrupted, it is likely to eventually result in death (Chicago Women’s Health Risk Study at a Glance, 2000). Intervention is most likely to be effective immediately after the Battering Phase. At that time the woman’s defenses are down and she feels most vulnerable. She is most aware of the impact of violence on her ability to function. As she moves into the Contri-
tion Phase she begins to feel stronger and more supported by her partner and may have more difficulty identifying the abuse as a problem.

ASSESSMENT

Occupational therapists routinely assess clients’ safety in their current living situations. Safety assessments typically should include both physical safety and safety in the social environment. In the context of different practice settings, this safety assessment will take on different meaning. For instance, when the therapist is evaluating an individual’s ability to return home independently after rehabilitation, the physical environment is always considered. Therapists routinely consider the availability of adapted bathroom equipment and grab bars, the placement of scatter rugs and whether or not a client can safely navigate in the kitchen. Likewise, a therapist who is working with a parent and child who live in a high crime community will assess the social environment for safety. Returning to an unsafe social environment will challenge the parent’s ability to provide safe play opportunities for his/her child. While it may seem obvious to include family violence in a safety assessment, most therapists do not consider it part of a routine evaluation. Every occupational therapist should include the client’s risk for domestic violence as part of a general safety assessment.

An ideal framework for assessing and understanding this population is The Model of Human Occupation (MOHO) (Kielhofner, 1995). This model was chosen because it permits persons to be viewed holistically and captures how the women function in their environment, while examining their roles, volition and habits. Table 1, “The Model of Human Occupation Applied to Domestic Violence,” provides an out-
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<td>1. Are there activities you enjoy doing alone?</td>
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<td>1. Are there physical, emotional and/or cognitive limitations that affect your ability to get done what you need to day to day?</td>
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<td>2. Are there physical, emotional and/or cognitive limitations that inhibit you from leaving your abuser?</td>
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line of the domestic violence issues that relate to each subsystem of the model of human occupation.

Several tools based on The Model of Human Occupation provide a comprehensive assessment of women who are victims of domestic violence, including their self-care skills, communication/interaction skills, self-assessment skills and life history. The tools discussed in this article include:

2. The Occupational Self-Assessment (OSA) (Baron, Kielhofner, Goldhammer, & Wolenski, 1999).

**Occupational Performance History Interview-II (OPHI-II)**

The OPHI-II is a semi-structured instrument that is administered in order to collect historical data on daily life experiences and on the impact of the environment on those experiences. The interviewer completes rating scales that explain the clients’ values, self-esteem, lifestyle pattern, and environmental supports and constraints. The interview process takes one to two hours to complete.

This interview is comprehensive, allowing the interviewer to address past, current and future experiences. Although the tool allows a person to discuss the above areas, it does not speak to this population’s specific experiences of being in an abusive relationship, and/or residing in an emergency shelter. However, because the OPHI-II is a life history narrative, it allows the therapist to address past and present domestic violence experiences. Obtaining this type of information can help the therapist identify life patterns and problem solving abilities.

**Occupational Self-Assessment (OSA)**

The OSA is a self-report, administered to measure the women’s self-perception of their abilities, their satisfaction with their perfor-
mance, and their views of the environment’s effects on their performance. The OSA can be administered by the occupational therapist, or the client can choose to complete the assessment independently, and then review it with the occupational therapist. The OSA provides women the opportunity to self-reflect on their assets and limitations. It also affords women the opportunity to choose areas of personal importance that they would like to change. In many instances women are unable to make choices based on personal values due either to their abuser and/or the demands placed on them by the shelter. It also is an opportunity to discuss the impact of their environment on their ability to function.

The authors found it difficult to use the OSA with women who are concerned about potential declines in functioning in the future. For example, one of the women who completed the OSA reported “Taking care of myself” as a task she performs “very good” and is of “extreme importance”; however, this was an area she also identified as wanting to change. When questioned on her rationale for choosing to change how she is able to perform in relationship to this item, she summarized it by saying that this is an area she is able to do well currently due to the support of her environment. Conversely, she realizes that once she leaves the shelter environment, this is an area that may be difficult to maintain, due to the loss of structure and support provided through the shelter. This is indicative of a need to not only provide services for the women’s current needs, but to also address their future service needs. Therefore, therapists need to closely examine skill areas being performed well and inquire as to whether or not women feel this may be difficult after leaving the shelter environment.

Assessment of Motor and Process Skills (AMPS)

The AMPS is an observation tool used to measure the motor and process skills of a person as routine tasks of personal significance are performed. This allows the observer to assess areas affected by a person’s disability on their performance. Prior to observing two-three tasks, the client and the occupational therapist negotiate a task that the client performs routinely, while also ensuring that the task is not too easy or too difficult. The occupational therapist should aim for a “just right” challenge when selecting tasks. Once tasks are determined, the observer and client should discuss the specifics of the task
to be performed in order to eliminate ambiguity as the client performs the task (e.g., deciding what type of bread, spread and meat the client will use to make a sandwich), and also where the tasks will be performed (e.g., common shelter living area vs. shelter resident’s apartment).

Allowing the client to choose activities of personal significance that are performed routinely supports an increased sense of internal control. This is of great importance because many women who are in abusive situations do not have the opportunity to choose tasks that are important to them. Choosing activities also allows the women to feel in control of their actions. Often women in abusive relationships do not have control over the tasks they perform or even how they perform these tasks due to the controlling nature of the abuser. Permitting the woman to have control also increases her ability to make choices, introducing the woman to new and/or previous roles.

Therapists using this tool should be cognizant of the similarities and differences of the client’s past, current and future environments. Women living in an emergency shelter are less likely to be familiar with their environment. They are put into situations where they cannot control with whom they are living (other shelter residents), or the neighborhood in which they reside. This environment may not be reflective of their previous and/or future environment. For example, a woman performed an AMPS task in the common living area of the shelter. This environment is reflective of her present living situation; however, it is not reflective of past and/or future environments, consequently, the assessment of her performance of the task may be inaccurate. Therapists should therefore be mindful in asking for information on the client’s future social and physical environment.

**The Assessment of Communication and Interaction Skills (ACIS)**

The ACIS is an observational instrument. The ACIS assessment can be performed observing the client interacting with one person, in a group environment, or during 1:1 interactions with the client. The ACIS is used to analyze the behavior of a person when interacting in an individual and/or group setting. This tool allows the observer to assess areas such as social appropriateness, body language, and eye contact when interacting with one or more persons.

The ACIS allows a therapist the opportunity to evaluate social appropriateness (or inappropriateness) when a person interacts with
others. However, the ACIS does not have a built-in mechanism for clarifying specific communication styles or mannerisms. This may be a crucial component for this population because their communication styles may have been influenced by previous interactions with their abuser. For example, one woman demonstrated an inability to make decisions regarding when and where the assessment process would take place. Although her score on the ACIS for “conforms” was high, her conformity (the ability to follow implicit and explicit social norms) made it difficult to schedule a meeting time and place. This behavior did not give the authors a good sense of what would be most convenient for her. Thus, her “over-conformative” behavior has implications for her ability to make her needs known to others. Conforming may have been an effective adaptation to her specific domestic violence situation; however, the same behavior may prove to be ineffective in many other situations.

During the assessment process, therapists who work with women who are victims of domestic violence need to appreciate the adaptive behaviors acquired by this population. Therapists should help women to identify these adaptive behaviors in order to assist them in recognizing their ability to change their domestic violence situation should this be of interest to the woman. In order to assess a woman’s readiness to discuss her domestic violence situation, it is important to begin with global questions regarding her well-being and safety.

The assessment of domestic violence should begin with a general assessment of the client’s safety in her home and living situation. After this assessment has been completed the following direct questions are recommended:

1. Do you feel safe at home?
2. Has there ever been a time when you did not feel safe at home?
3. Are there any situations in your life where you do not feel safe?
4. Is there anyone or anything that threatens your sense of safety?
5. Is anyone hurting you or your children?

These questions are recommended to ascertain if the client is currently in an abusive situation. The question, “Has there ever been a time when you did not feel safe at home?” refers to past abuse and is included here because of the repetitious nature of the cycle of violence (Walker, 1979).

These questions intentionally do not refer to “abuse” directly. The
therapy should use clinical reasoning and careful judgment to follow up with the client on each of these questions. Simply inquiring, “Can you tell me about that?” will often open the door for discussion. Many clients will be relieved to have the opportunity to discuss their living situation with the therapist. At the point where the client has begun to trust the therapist, the therapist is in a better position to question her directly about her experiences with abuse. The therapist can then ask directly if the woman is being abused, what type of abuse is occurring, and how she feels about her situation. It is not uncommon for a woman to deny being abused and then minutes later to disclose that her partner “pushes her around” once in awhile. This does not necessarily mean that the woman is deliberately denying that she has been abused. Instead, it often indicates a lack of knowledge on her part that the behaviors she is describing are abusive. Women who were raised in abusive homes may not identify behaviors as abusive because they are experienced as normative to her. For these reasons, it is often not useful to initially ask a woman if she is being “abused.” Focusing questions around being safe or being threatened may result in clearer answers.

In any area of practice the therapist must consider who else is present when questions regarding safety or abuse are being asked. Questions must never be asked in the presence of the person suspected of being the abuser. Asking questions in the presence of the abuser may place the woman at greater risk for further abuse. Even if she denies the abuse, the abuser may accuse her of leading the therapist to ask her about it. In some settings, such as home health care, finding a place to speak confidentially will be very difficult. The occupational therapist may need to be creative in order to create a context in which she can speak to the woman privately.

**OCCUPATIONAL THERAPY INTERVENTION**

Once the client discloses information that indicates the possibility of abuse, the therapist has an ethical obligation to respond in some manner. How the therapist chooses to respond will vary depending on state legal requirements, the treatment setting, theoretical beliefs and the therapist’s skills and attitudes about his or her professional role. The response of the occupational therapist may occur in any of five ways: (1) following the legal requirement to report abuse, (2) initiating refer-
ral to resources or services, (3) offering direct treatment, (4) providing indirect services, or (5) utilizing program consultation. These types of intervention may be provided individually or as part of a collection of efforts by the therapist and other members of the health care team. Each type of intervention will be described with case vignettes to illustrate its application as occupational therapy.

**Level 1: Report**

Some states have mandatory reporting laws for domestic violence. Legal requirements range from the need to report any case of suspected abuse to those that only require reporting in cases where a deadly weapon was used. Each therapist should consult the Domestic Violence Act and Occupational Therapy Practice Act of his/her own state for details.

*Illustration:* An occupational therapist practicing in home health observed a situation where she suspected abuse. When she reported her findings to the team, there was a mixed response. Some members of the team felt that the bruises she observed were simply from the woman’s clumsiness and awkwardness adjusting to her new adaptive equipment. Other team members supported the OT’s suspicion that the physical bruises, in combination with the client’s vague statements about how poorly things were going at home, were indicative of possible abuse. In some states the therapist would be required to report these suspicions to the authorities.

**Level 2: Referral**

The occupational therapist may offer several types of referrals to a client who is either suspected of being a victim of abuse or who chooses to disclose her abuse. Referrals for domestic violence services include emergency housing, legal advice and assistance, and domestic violence counseling. Other types of referrals could include services for her children, psychotherapeutic counseling, or medical care.

The woman who is being abused is likely to be isolated from supportive friends and family either by the abuser or by having iso-
lated herself to hide the abuse. In either case, she will need to rebuild a support system in order to heal and continue on with her life. The occupational therapist can refer her to support groups and agencies, which specialize in treating adult victims of domestic abuse. Most of these agencies also either provide services for children or will provide referrals for the children.

Clients may be relieved or pleased to receive referrals. They may also become very angry at the occupational therapist for suggesting that there is a domestic problem at home and refuse to accept any information. The Cycle of Violence (Walker, 1979) as a frame of reference can provide a way to understand the various ways that a woman might respond to the offer of a referral or the suggestion that she may benefit from assistance.

Whenever the therapist decides to offer information, the woman’s safety must be given first consideration. Awareness of the form in which information is being provided and the environmental surroundings is critical. The information must be provided in a way that does not place the client at greater risk for abuse. Placing information in women’s restrooms within the OT clinic area provides an opportunity for women to learn about domestic violence without their abuser’s knowledge. Pamphlets and written information that could be found by the abuser are potentially dangerous to the woman. If her abuser finds domestic violence related literature on her person or with her belongings he may “punish” her for exposing his behavior to others. The occupational therapist must always respect a woman’s judgment if she believes that accepting written information could be harmful to her.

Occupational therapists must be aware of local domestic violence crisis line numbers. Therapists should also be able to direct women or assist them to obtain basic information on safety and the availability of resources for her and her children. Therapists are encouraged to contact their local or state domestic violence coalitions for further information. The National Domestic Violence Hotline number is 1-800-799-SAFE (7233).

**Level 3: Direct Treatment**

Occupational therapy can offer many treatment options to a woman who is in an abusive situation. Occupational therapy, which directly addresses the issues of domestic abuse, may include the development
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of skills needed for successful role performance of desired roles, independent living skills, environmental adaptations, exploration of new roles, and educational, prevocational, or vocational treatment. Occupational therapists have an ethical responsibility to inform women of their treatment options. This would include options for maintaining the safety needed to pursue treatment.

The treatment setting and funding options available to the woman will influence provision of direct services. Occupational therapists who work in domestic violence settings are likely to work for the domestic violence agency and may be able to provide needed therapeutic services without seeking third party reimbursement. Hospital-based therapists are not as likely to have services paid by the agency. The issue of reimbursement should not prevent service provision. Instead, the hospital-based therapist may be more challenged to carefully identify the functional components which are most directly impacted by the domestic violence, and provide appropriate therapy services to address those issues.

Illustration: A woman living in a transitional housing facility reported difficulty in effectively managing her anger, and expressed an interest in learning appropriate assertiveness techniques. She stated that she often keeps her anger bottled up and becomes depressed rather than letting others know how she feels. The OT in this setting worked with the client on learning to express herself and control her anger through assertiveness, and anger and stress management training.

Another woman reported problems in organizing her daily routine, making it difficult to complete tasks throughout the day. The OT in this setting assisted her to develop and use a schedule/planner to organize her day. Together, they solved the problem of how to prioritize tasks throughout the day.

Level 4: Indirect Services

Occupational therapy may have a more effective role with victims of domestic violence through indirect service provision. Services are provided indirectly when the therapist works through non-occupational therapy staff to deliver services to clients. The therapist may offer training to staff to allow them to carry out recommended programs in the absence of the therapist. Because funding in domestic violence
agencies is scarce, an occupational therapist may have more opportunities to provide services in this manner. The therapist who works in this type of setting may charge for consultation or may be there as a student-therapist completing a community-based field rotation under the direction of an occupational therapist. Occupational therapists can also provide in-service presentations to staff as part of a staff training program.

*Illustration:* Staff working with women in a transitional housing program reported that women were unable to follow through with their goals. The OT at the site worked with the staff to establish techniques for working with the women by educating the staff on how to help their clients establish realistic goals. This was accomplished by training the staff to break-up goals into multiple steps in order to make them more attainable. This assisted both staff and clients to see progress toward their goals which led to a higher percentage of clients following through and accomplishing their goals.

**Level 5: Program Consultation**

Occupational therapists also may provide program consultation in domestic violence programs. The occupational therapist’s knowledge of systems, the environment, and activity analysis can be used for program consultation. The therapist may begin with a needs assessment and expand to a wide variety of roles. The therapist can collaborate with staff on program planning to develop life skills or community reintegration, to recommend participation in vocational and educational programs, or to expand an intake assessment process to include functional components. A relationship that begins as consultative may expand to include both additional areas of consultation or the development of a permanent position for an occupational therapist within an agency.

*Illustration:* A recent student project included a pilot needs assessment of 16 women that utilized the Occupational Self Assessment. The women identified stress management, finances, time management and opportunities to do things they valued as areas on which they needed to work. Through informal interview they also identified assertiveness/self-expression and goal setting...
as areas of need. The students used this information to create resource materials for staff that focused primarily on budgeting and stress management. The staff reported that the resource book was a useful tool. They expressed a desire to have more comprehensive information available to them to make informed decisions about programming.

**REASONS WOMEN REFUSE INTERVENTION**

Despite offering information or interventions to a woman, she may not accept it when it is offered. The refusal of assistance can be frustrating for occupational therapists; however, the therapist should not feel his/her efforts have been futile. The average woman leaves her abusive partner five to seven times before staying away (Russell, 1995). There are a variety of reasons that a woman may refuse assistance and choose to stay in, or return to, an abusive relationship. These include: economic pressure, belief he will change, fear of being harmed, no place to go, love, fear of being alone, concern for the children, guilt, concern for the abuser, and pressure by others (NCarthy, 1982).

This range of experiences contributes to why the woman has difficulty leaving the relationship. It is important for the therapist to know that even if an intervention is initially refused, the intervention may still have an impact on the woman’s life. She may remember the intervention or return to the information provided, weeks, months or years later when she is ready to accept it. Women have called crisis lines and arrived at emergency shelters with referrals from all types of sources (Helfrich, 1997). As information providers, occupational therapists cannot always know when a client will use the information provided.

**CONCLUSION**

Occupational therapists will work with victims of domestic violence in every setting. The role of the therapist in each case will be determined by the client’s needs and the therapist’s skill and attitude regarding domestic violence. This variability must change and it should become standard practice for occupational therapists to consid-
er it ethically necessary for the domestic violence to be addressed. Education and role modeling will facilitate this change.

This article has provided a theoretically based outline of assessment and treatment procedures for the occupational therapist. Each occupational therapist is challenged and encouraged to pursue this information and acquire the essential knowledge to treat this critical population.

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