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Occupational Therapy and Victim Advocacy

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SUMMARY. This article provides an orientation to increase the profession's awareness of occupational therapy's role in victim advocacy, an emerging area of community-based practice. Analysis and comparison of OT's core assumptions and values with general principles of victim advocacy and empowerment demonstrate striking similarities: Each acknowledges holism and a profound connection between the individual and society, as well as their ability to interact and influence each other. In addition, the cultures of OT and victim advocacy both value the dignity and worth of persons, self-determination, freedom and autonomy, latent capacity, human uniqueness and subjectivity, and active and mutual cooperation in restoration or recovery. The compatibility of OT and victim advocacy is further demonstrated in the context of one therapist's work with survivors of domestic and sexual violence. [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.]

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In order to be a true advocate, it is critical to change beliefs and accept truths about domestic violence. (Missouri Coalition Against Domestic Violence, 1998, p. 9)

Over the last quarter of the twentieth century, domestic and sexual violence emerged as major threats to the health and well-being of women and children in the United States (U.S. Department of Justice, 1998). For many survivors, the reality of being trapped by repeated assaults and coercion is equivalent to living in a war zone. Consequently, the negative impact of experiencing familial abuse can be devastating for children. Research has even demonstrated a generational link between childhood exposure to violence in the home and mental health problems later in life (Henning, Leitenberg, Coffey, Turner, & Bennett, 1996).

Although the prevalence and severity of domestic and sexual abuse have been well-documented, contemporary society has largely failed to address these issues. Recent increases in public and private spending have led to improvements in overall awareness and initial response; however, many cultural institutions (i.e., education, health care, social services, etc.) remain ignorant and unresponsive to the reality of those experiencing intimate violence and coercion. This lack of information and scarcity of adequate training reinforce the isolation that perpetuates victimization. Failure to break the cycle of violence imposes an enormous cost to society and individuals. While the annual medical expense of violent crimes is estimated in the billions (Miller, Cohen, & Rossman, 1993), the loss of human potential is immeasurable.

In the absence of uniform, public policies and educational initiatives that focus on a comprehensive response to victims, the battered women’s, or advocacy, movement has relied considerably on the individual efforts of local grassroots coalitions to raise awareness and coordinate victim service. This has resulted in an uneven distribution of information and support. While advocates and their allies have argued that the most effective interventions involve a coordinated community response, some health care practitioners, including occupational therapists, have not taken an active role in collaborations. For many, it seems as if it has been easier to ignore, than to accept, that intimate abuse is a fundamental health care imperative. The Medical Power and Control Wheel (Figure 1) illustrates how such ignorance creates an ineffective health care response that re-victimizes battered women.
Today most major health care disciplines have adopted uniform guidelines and standards of practice for working with battered women (Stark & Flitcraft, 1996), yet professional literature regarding the occupational therapist’s role in addressing victims’ needs is grossly deficient. Accordingly, occupational therapists report that relatively few OT programs give sufficient attention to the dynamics of domestic and sexual violence and their impact on occupational performance (Johnston, Adams, & Helfrich, 2001). It should not be surprising that occu-
Pational therapists’ (OTs) reluctance to address violence against women is a mirror of the health care system and society’s broader failure to afford adequate attention to, and protection for, battered women. Without proper education, training, or empathy, occupational therapists do not acknowledge their potential responsibility in assisting victims and thus, feel ill-equipped to screen for and respond to those needing safety and support from further acts of abuse (Johnston, Adams, & Helfrich, 2001).

Effectively challenging the professional and institutional ignorance regarding domestic abuse means peeling away layers of disregard, misinformation, and apathy. Therefore, changes must occur on a variety of levels: gaining a more accurate understanding of the victim’s reality, identifying appropriate intervention strategies, increasing community collaborations, and redefining professional roles (Wilson, 1997). Reexamining OTs’ way of thinking about human occupation, dysfunction, and adaptation within the context of intimate violence will enable therapists to adapt their unique skills to coordinate and implement quality interventions with victims of abuse.

**OCCUPATIONAL THERAPY: CORE ASSUMPTIONS AND VALUES**

Over a century ago, the novelist George Eliot wrote, “It is never too late to be what you might have been” (Chaffee, 1998). Indeed, the culture of occupational therapy has always focused on transforming people’s lives through being, doing, and ultimately becoming (Wilcock, 1999). Nearly eighty years ago, Adolph Meyer (1922) asserted the necessity of occupation in daily life. Two decades later, occupational therapists were applying this notion to the care and rehabilitation of casualties from two world wars. As moral treatment gave way to the mechanistic paradigm, the result was a crisis of confusion within the profession. Since then, OT has attempted to reclaim its foundation in occupation while embracing a more holistic and open framework to include the mind, body, and environment. Kielhofner (1992, pp. 48-49) refers to this “emerging paradigm of occupational therapy” as a model which reflects the following three assumptions:

1. Human beings have an occupational nature.
2. Human beings may experience occupational dysfunction.
3. Occupation can be used as a therapeutic agent.
Furthermore, Kielhofner (1992, p. 76) describes the values which shape the profession's practice:

Occupational therapy’s values affirm human dignity and worth and the right of persons to their own perspectives and to self-determination. These values also recognize the importance of building on an individual’s capacities, however limited, by allowing participation in occupation as a means of achieving a more healthy state. These values also ensure the person’s right to compassionate care as they struggle to attain or maintain a level of function.

From the beginning, it has been the consistent demonstration of these core assumptions and values which has enabled OT to provide unique solutions to the restoration of individuals and society; however, as a profession, OT has ignored the casualties of another war that has been fought by a silent majority for centuries. Certainly, the profession exists because “it has an implicit social contract to address the problems of those members of society who have limited capacity to perform in their everyday occupations” (Kielhofner, 1992, p. 3). Yet, for the victims and survivors of domestic and sexual violence who are finally gaining access to health care institutions, OT has not kept its promise to address the needs of the time. Thus, the profession seems stuck between the progress of recognizing social change and the transformation to a sensitive, appropriate, and collaborative response to victims and survivors of domestic and sexual violence. Further, OT needs to coordinate this response with other health care professionals and with victim advocates.

PRINCIPLES OF VICTIM ADVOCACY AND EMPOWERMENT

Bolstered by the feminist and anti-rape movements of the 60s and 70s, the battered women’s movement arose from the need of a flood of victims who turned to the earliest advocacy services in the country for support (Jones, 1994). In the 1970s with the establishment of the first rape crisis hotline in Washington, D.C., and the first domestic violence shelter in St. Paul, Minnesota, victims of domestic and sexual violence were finally given an opportunity to share their stories. Advocates
engaged in these initiatives challenged the popular belief that violence in the home was a “private matter of the family” and introduced the abuse of power and control in intimate relationships as a public concern. They argued that abuse exists because of gender inequities and a history of oppression which subjugated women in society (Stalans & Lurigio, 1995).

By the mid 1970s, political leaders could no longer ignore the plight of abused women, and state governments began passing adult abuse protection laws, providing civil protection remedies (i.e., restraining or protective orders) for victims of intimate violence. In 1994, Congress passed the Violence Against Women Act (VAWA) to improve the safety of women nationwide. The VAWA not only increased penalties for some crimes against women but also provided for state grants to support law enforcement and educational programs aimed at reducing violent crimes against women. Despite these excellent strides, protection for survivors of domestic and sexual abuse is only as effective as the people who endorse or enforce such measures. As a result, the burden of safety often falls upon the victim herself as communities continue to struggle with challenging and changing the social acceptance of violence against women.

The core assumptions that underlie victim advocacy services for survivors of domestic abuse can be summarized into three areas:

1. The essential need for and right to safety,
2. The recognition that intimate violence and coercion pose unique challenges to the individual and society,
3. The value of empowerment in the restoration of survivors.

Advocates who empower and assist victims to well-being are concerned above all with the safety of the victim and her children. Safety is a basic human need (Maslow, 1954) and a fundamental right in any human relationship. Domestic and sexual violence are violations of that primary need for safety and security. Because a victim’s greatest risk for harm occurs at the point in which she takes steps to end the abuse, every interaction and intervention must consider her safety and her assessment of the situation (Missouri Coalition Against Domestic Violence, 1999, p. 3).

In addition, domestic and sexual abuse are phenomena fraught with contradictions, working against the presupposition of mutuality and
equality in a committed relationship. Explaining the victim's experience, Bard and Sangrey (1986, pp. 8-9) write that

People can adjust to reality when they know what to expect. Experiences that meet our expectations are easier to handle, even if they are difficult and painful. But whenever experience fails to meet expectations, a person's ability to cope is compromised.

This description underscores the profound difficulties that many women face in accepting the dynamics of abuse within a relationship where love and intimacy coexist with power and control. Furthermore, it illustrates the enormous challenge facing communities struggling to accept that intimate violence simply exists. Recognition of this challenge can assist advocates in their efforts to validate and restore the survivor in her community which often blames the victim or ignores her situation.

Furthermore, advocacy services for battered women have always been founded on basic principles of empowerment. In Webster's Ninth New Collegiate Dictionary (1986), empowerment is defined as "investing with power or the right to act." For the purposes of advocacy, to empower is to assist, facilitate, help, support, and ultimately restore the individual. "Empowerment affords a battered woman the opportunity to see herself as a strong survivor who can participate actively in securing a safe and independent life" (Missouri Coalition Against Domestic Violence, 1999, p. 27). Developed by the Domestic Violence Project, Inc. in Kenosha, Wisconsin, The Empowerment Wheel highlights six ways in which advocates and others, who work with victims of domestic and sexual violence, can help to restore the individual to well-being. (See Figure 2.)

The philosophical underpinnings of empowerment will be further discussed in the next section as comparisons are drawn between the core assumptions and values of OT and victim advocacy.

**MAKING THE CONNECTION**

Domestic and sexual abuse should not be viewed as social ills to be eradicated or ignored. Through the skillful eyes of an OT, they might be perceived as Christiansen (1999) asserts, as "assaults of meaning,
phenomena that cause individuals to lose their sense of purpose and meaning in life.” As one survivor of domestic violence explained:

You cannot emerge a whole human being when you escape someone who constantly beats and berates you physically, emotionally, and spiritually. Until that searing of the soul has been attended to . . . There is something which happens to the psyche. The wholeness of the individual must be looked at. They must begin to understand what has happened to them and why. (Raphael & Tolman, 1997, p. 8)
This statement reflects many fundamental OT beliefs: a holistic understanding of identity and well-being, an appreciation of the multifaceted nature of occupational performance, dysfunction, and adaptation, and acknowledgment of the inextricable link between the individual and the environment.

Further synthesis of victim advocacy with OT core assumptions and values reveals even more similarities. Themes that recognize the dignity and worth of individuals, validate the victim's experience, respect the right to autonomy, and promote active participation in restoration and recovery underlie empowerment. These same values guide OT practice, allowing the therapist to view the survivor's level of function as a result of adaptations rather than pathologies. Although both cultures acknowledge the assumption of safety for active participation in occupations, OT has been far less apt to practice this belief with battered women because the profession has largely ignored the victim's reality.

The work of an OT in a victim advocacy setting involves offering safety, support and resources to someone seeking refuge from violence and intimidation. Upon initial contact, the OT or advocate will assess the victim's risk for harm and begin gathering information to assist her in organizing a plan of action. This helps her take steps to regain control of her physical, emotional, social, financial, educational, and spiritual well-being. Because the level of involvement must be dictated by the particular needs of the individual seeking assistance, advocacy services will vary accordingly. While the OT may only need to inform some women about available community resources (i.e., housing, food, financial assistance, counseling and support, etc.), intervention may also include encouraging and facilitating participation in occupations once denied the victim. For example, with concurrent safety planning, the therapist can help the survivor find and secure employment after years of being denied the opportunity to work. Participation in employment is often restricted by the abusive partner who views this activity as a threat to his control. Overall, the challenge is not simply working with the victim of domestic violence, but working with this particular victim of abuse and her individual needs.

OT becomes a crucial part of victim advocacy when therapists provide safe environments that empower people to explore their potential and achieve success in daily tasks that are essential to well-be-
OT’s unique perspective on role acquisition and identity can enhance the survivor’s understanding of her situation and motivation to engage in meaningful activities. Participation in occupations are opportunities to express the self and to create an identity (Christianesen, 1999). When applied to the victim’s reality, these activities are vital to the restoration of someone whose identity has been compromised or lost as a result of previous abuse. Within the frameworks of OT and victim advocacy, the therapist may validate a new identity or empower the victim to recover a role previously denied her. Ultimately, this work not only assists the individual but also restores her connection with the community.

THE ROLE OF AN OCCUPATIONAL THERAPIST WITHIN A COMMUNITY-BASED ADVOCACY PROGRAM

Over the last three years, I have worked in various aspects of victim advocacy service delivery. From volunteer board member to Victim Advocate to Program Director, each role has given me opportunities to apply my OT skills in order to enhance advocacy services in a rural community. For instance, utilization of activity analysis has enabled me to reduce the complex task of organizing and implementing an advocacy program into its components. This has facilitated my ability to assess the community’s needs, author grant proposals, organize victim services, develop collaborations with community service providers (i.e., law enforcement, civil and criminal justice personnel, social service workers, etc.), and measure program efficacy.

As the characteristics of a community shape organizational goals, the needs and resources of individual battered women direct the level of service provision by OT. Some survivors only need the therapist to serve as a consultant, linking them with community resources they have been isolated from in the past. Others may benefit from more intensive case management services in which, after gaining relevant background information, the OT develops an individualized goal or action plan. Each situation requires that the therapist or advocate make a comprehensive initial assessment of the victim’s safety, measuring her risk of harm with available resources and support. This can be especially challenging when the victim herself is in a state of crisis (i.e., physical, emotional, spiritual, etc.) or when the victim has a mental illness, developmental delay, physical disability, or other spe-
cial need. Nevertheless, “All women should be screened for domestic violence, because it is too common and too serious a problem to remain unidentified” (American Physical Therapy Association, 1997, p. 9). Helfrich and Aviles (2001), provide a useful framework for assessing the role of OT. Their paper also provides examples of intervention at various levels.

Baum and Law (1998, p. 8) suggest that “we must initiate efforts to work with others in the community in order to integrate a range of services that promote, protect, and improve the health of the public.” Regardless of my professional role, I have gained a heightened appreciation of OT’s potential to offer significant and unique contributions in the area of victim services.

CONCLUSION

As a profession and as individuals, we must prepare ourselves for this truth: Domestic and sexual violence is a reality for countless individuals who may receive OT services within a health care setting as well as community-based practice. First and foremost, therapists must educate themselves about the cycle of abuse, its effects on occupation and identity, and how to safely empower survivors. Information gives all of us strength and empathy (Robin Warshaw, 1994, p. xxvi). Some therapists already have and others are willing to receive it. The rest we still need to worry about, but the rest are within our power to change. That potential to be agents of change in the lives of others and our communities must be OT’s greatest motivation to offer its unique understanding and expertise in building a nonviolent future for everyone. OT must assist in constructing a sensitive, appropriate, and coordinated response that asks each survivor what she needs to repair the harm of abuse.

Organizations, Agencies, and Coalitions

Center for the Prevention of Sexual and Domestic Violence
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Seattle, WA 98103
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www.cpsdv.org
Recommended Reading


REFERENCES


