Occupational Therapy Services for Individuals Who Have Experienced Domestic Violence (Statement)

Purpose
The primary purpose of this paper is to define the role of occupational therapy and the scope of services available for survivors and families who have experienced domestic violence. This document is intended for use by occupational therapists, occupational therapy assistants, and individuals interested in this topic as it relates to the occupational therapy profession.

Introduction to Domestic Violence
Domestic violence is a societal problem in the United States and abroad that affects not only the survivor of the violence but also the children witnessing it, the family and friends of the survivor, and the communities in which it occurs. Domestic violence affects 1,500,000 women and 835,000 men in the United States each year (National Institute of Justice [NIJ], 2000). In the United States it is estimated that 1 in 3 women have experienced domestic violence in an intimate relationship (Heise, Ellsberg, & Gottemoeller, 1999; Helfrich, 2001). These statistics do not account for those men and women who have not spoken up and admitted that they are survivors of domestic violence or for the lasting effects that violence has on children and families. The term victim is sometimes used to describe individuals who are currently in an abusive relationship. The term survivor is used to describe individuals who are currently in the abusive relationship or who have overcome the abuse. The term survivor is viewed as more empowering and denotes the great strength and courage needed to endure and survive domestic violence.

There are numerous definitions of domestic violence depending on the state and organization. This document defines domestic violence as a pattern of coercive behavior designed to exert power and control over a person in an intimate relationship through the use of intimidating, threatening, harmful, or harassing behavior (Office for Victims of Crime [OVC], 2002). Domestic violence therefore focuses on intimate partners. Child and sibling abuse also may occur concurrently with or as a consequence of living in a domestic violence situation. Although women are abused in 85% to 95% of the reported domestic violence cases (Fisher & Shelton, 2006), men also are abused. New research suggests that women may be abusers in intimate relationships more often than previously thought (OVC, 2002). Therefore, it is important to view domestic violence as an issue of obtaining power and control over a partner rather than as a gender issue. Domestic violence occurs in both heterosexual and homosexual relationships at nearly the same rate. Survivors of domestic violence in a homosexual relationship, however, may have more difficulty accessing services and may face further oppression.

Additionally, women with disabilities who are abused may face additional barriers that make it more difficult to leave the abusive relationship and access services. Although there are inconsistent findings regarding the incidence of abuse of women with disabilities, several sources indicate that they are assaulted, raped, and abused at a rate twice that of women without disabilities (Helfrich, 2001; Helfrich, Lafata, MacDonald, Aviles, & Collins, 2001). These studies indicate that women with disabilities may be dependent on their partners for financial, physical, or medical support, and thus may stay in abusive relationships for longer periods of time (Helfrich et al., 2001; NIJ, 2000). Their abusers may withhold necessary equipment such as wheelchairs, braces, medications, and transportation as a means to control them (NIJ, 2000).

Domestic violence also affects older adults. The National Coalition Against Domestic Violence (NCADV) defines elder abuse as abuse by an intimate partner rather than by a caregiver (NCADV, n.d.). Domestic violence in older adults has unique considerations that include the chronic effects of abuse over many years, guilt mixed with a sense of responsibility to be the caregiver for the abusive partner, and conditions such as Alzheimer’s that may mask signs of abuse or exacerbate behaviors (NCADV, n.d.).

The effects of domestic violence on children can be devastating as well. In addition to experiencing the abuse between their parents or a parent and partner, it is estimated that child abuse occurs in 30% to 60% of domestic violence cases (Appel & Holden, 1998; McKibben, DeVois, & Newberger, 1998). These children often have low self-esteem, psychosomatic complaints, nightmares, impaired social skills, and poor academic performance. They may be aggressive, withdrawn, anxious, depressed, and even suicidal (OVC, 2002). In families of domestic violence, young boys may model their father’s behavior, while girls may model their mother’s behavior and show more signs of withdrawal and isolation (Cummings, Peplar, & Moore, 1999; Huth-Beck, Levendosky, & Semel, 2001; Stiles, 2002). According to the OVC (2002), some children will begin to disrespect the victim of domestic violence and identify more with the abuser, modeling the manipulating power that the abuser has over the victim and the children living in the household where domestic violence is occurring. Domestic violence knows no boundaries; it crosses into all socioeconomic classes, races, societies, and ages, regardless of the sexual orientation that defines the relationships. The key issue in domestic violence is the use of a pattern of abusive behavior by the abuser to establish fear, power, and control over an intimate or formerly intimate partner.

Abuse in domestic violence comes in many forms. It may be physical, psychological, or sexual. Physical violence may include such behaviors as hitting, slapping, punching, or stabbing. Psychological
violence may take the form of verbal abuse, harassment, possessiveness, destruction of personal property, cruelty to pets, and isolation (NCADV, n.d.; OVC, 2002). Sexual abuse can occur between two intimate partners when the abuser forces or coerces the victim into a sexual act. The abuser often isolates the victim from family and friends, thus limiting access to support systems. The abuser may control the finances, leaving the victim with no money or a limited allowance. It is particularly difficult for a woman to leave her abuser when she has no financial means to support herself and her children.

Research indicates that women who are survivors of domestic violence may struggle when performing a number of their daily life occupations or activities, particularly in the areas of work performance, educational participation, home management, parenting, and leisure participation (Gallew, Krabacher, Andriacco, & German, in press; Gorde, Helfrich, & Finlayson, 2004). They may have difficulty with cognitive functioning, including decision making, judgment, problem solving, and following directions. They may experience problems with money management, task initiation, self-confidence, coping skills, stress management, and interpersonal relationships (Carlson, 1997; D’Ardenne & Balakrishna, 2001; Levendosky & Graham-Bermann, 2001; Monahan & O’Leary, 1999).

Studies of children exposed to domestic violence indicate that they may have difficulties with self-calming, sleeping, and eating activities; may demonstrate developmental delays or maladaptive behaviors; and may have poor verbal and social skills that negatively affect their academic performance. They also may have higher rates of somatic complaints and interpersonal problems (Cummings et al., 1999; Huth-Beck et al., 2001; Norwood, Swank, Stephens, Ware, & Buzy, 2001; Sternberg et al., 1993; Stiles, 2002).

Occupational Therapy and Domestic Violence

In its broadest sense, the domain of occupational therapy is the facilitation of the ability of people to engage in their daily life activities—occupations—in a manner that supports their full participation in various contexts and that positively affects health, well-being, and life satisfaction (American Occupational Therapy Association [AOTA], 2002). Occupational therapists and occupational therapy assistants view occupations as central to a person’s identity and competence, influencing how a person spends time and makes decisions (AOTA, 2002). Because domestic violence negatively affects the ability of the survivors and their families to engage in their daily life occupations in a competent, healthy, and satisfying manner, occupational therapy practitioners focus on developing or restoring these abilities. Specifically, occupational therapy practitioners focus on enhancing the ability of the survivors and their families to participate in activities of daily living (ADLs), instrumental activities of daily living (IADLs), education, work, leisure, play, and social participation for the purpose of gaining skills and abilities needed to take control of their lives and develop healthy independent lifestyles.

Occupational therapy practitioners work directly and indirectly with survivors of domestic violence and their families in a variety of settings such as hospitals, rehabilitation centers, outpatient therapy clinics, school systems, and community programs. Occupational therapy practitioners may work with survivors and family members who have

- Sustained injuries or disabilities as a result of domestic violence,
- Chosen to remain in and rebuild a relationship in which abuse has occurred, or
- Decided to leave the abusive relationship and reconstruct their lives.

In the course of their practice, occupational therapy practitioners also may work with individuals whom they suspect or discover are victims or survivors of domestic violence but who have not reported the domestic violence. In such cases, occupational therapy practitioners have a professional and ethical responsibility to take action that promotes the health and safety of these individuals. Occupational therapy practitioners are mandated to report suspected child abuse. Some states also mandate that they report suspected abuse in adults. Occupational therapy practitioners need to consult their state regulatory acts and facility guidelines regarding procedures they are to follow when they suspect or know that domestic violence has occurred. Actions that practitioners may take include

- Filing a report to the local law enforcement agency or children’s protective services;
- Interviewing, evaluating, and providing interventions without the abuser present to allow the client the opportunity to discuss the situation in relative safety;
- Identifying and assessing injuries and their potential cause;
- Talking to the client about healthy relationships, and addressing areas of occupation and performance patterns and skills that may have been affected by the abusive relationship such as leisure, IADLs, work, and ADLs;
- Respecting the client’s perception of the relative danger of the situation to his or her life and the well-being of other family members, and remaining empathetic and nonjudgmental about the client’s decision to remain in or leave the abusive situation;
- Providing the client with the phone number for the area domestic violence hotline; and
- Abiding by practice setting safety precautions to determine if it is appropriate to conduct home visits.

Occupational Therapy Services

The occupational therapy service delivery process occurs in collaboration with the survivors of domestic violence, their family members, and other service providers. Throughout the occupational therapy evaluation, intervention, and assessment of out-
comes, occupational therapy practitioners value and consider the desires, choices, needs, personal and spiritual values, and sociocultural backgrounds of the survivors and their family members. Occupational therapy practitioners also consider the service delivery context. Important outcomes of occupational therapy service provision include, but are not limited to, facilitating the ability of the survivors and their family members to consistently engage in and perform their daily activities, achieving personal satisfaction and role competence, developing a healthy lifestyle, and improving their quality of life.

The occupational therapy evaluation process is focused on finding out what the survivors and their family members want and need to do and identifying the factors that act as supports or barriers to performance of desired occupations (AOTA, 2002). Current occupational performance; routines and habits; activity demands; sociocultural beliefs/expectations; and physical, cognitive, and psychosocial factors are addressed during the evaluation process.

The occupational therapy intervention process is based on findings from the evaluation and the survivors’ and the family members’ stated priorities. It is the process of “effecting change in the client’s occupational performance, leading to engagement in occupations or in activities to support participation” (AOTA, 2002, p. 618). Interventions with adults who are survivors of domestic violence focus on empowerment and active participation in healthy occupations or daily life activities. These may include working on the development of a realistic budget, facilitating the use of effective decision-making skills regarding employment opportunities, learning calming techniques to use with their children, learning assertiveness skills, and teaching stress management and relaxation techniques to improve sleep patterns. Interventions with children who have witnessed domestic violence may include facilitation of developmentally appropriate play skills, social skills training, the use of techniques for improving concentration and attention span during school activities, and assistance with the organization of study habits and school materials.

Occupational therapy practitioners focus on outcomes throughout the occupational therapy service delivery process. Assessing outcome results assists occupational therapy practitioners with making decisions about future directions of interventions at the individual as well as at the systems level (AOTA, 2002). At the individual level, the selection of outcomes is based on the survivors’ priorities and may be modified based on changing needs, contexts, and performance abilities (AOTA, 2002). For example, an occupational therapy practitioner may work with a woman who is a survivor of domestic violence on her goal of obtaining housing. After the woman moves into the new living situation, the occupational therapy practitioner may help the woman work on her goal of maintaining a healthy home environment for herself and her children. At the systems level, data about targeted outcomes can be aggregated and reported to boards of directors of community agencies, state and federal regulators, and funding agencies. An example of this type of outcome assessment would be the reporting of the number of children who demonstrated difficulty participating in their daily life activities at home, school, and in their community because of exposure to domestic violence and the progress they made during the occupational therapy intervention to increase their level of healthy participation.

Occupational therapy practitioners also may work with the abusers in collaboration with other professionals such as psychologists, social workers, and pastoral counselors. Sometimes the judicial system issues a court order for the abuser to participate in a formal program to address the violent behaviors. These programs are generally based on six principles: (a) the abuser is responsible for the behavior, (b) provocation does not justify violence, (c) violent behavior is a choice, (d) there are nonviolent alternatives, (e) violence is a learned behavior, and (f) domestic violence affects the entire family whether it is directly or indirectly witnessed (OVC, 2002). Occupational therapy interventions with the abuser may include social skills training, assertiveness training, anger management, stress management, and spiritual exploration as related to daily life occupations.

Education, Training, and Competencies

Occupational therapists and occupational therapy assistants are educationally prepared to address the various occupation-related concerns of survivors of domestic violence. The Accreditation Council for Occupational Therapy Education (ACOTE) standards for educational programs require content related to daily life occupations, human development, human behavior, sociocultural issues, diversity factors, medical conditions, theory, models of practice, evaluation, and techniques for the development and implementation of intervention plans under the scope of occupational therapy (ACOTE, 2006). Occupational therapy practitioners are competent to address life skills, lifestyle management, adaptive coping strategies, adaptation, time management, and values clarification that affect the ability of survivors of domestic violence to participate in their ADLs, IADLs, education, work, play, leisure, and social participation activities. In addition, occupational therapy practitioners have the expertise to work with individuals and groups. Occupational therapists, and occupational therapy assistants who are supervised by an occupational therapist, are competent in the following areas:

- Establishing and maintaining therapeutic relationships
- Conducting interviews
- Administering functional assessments to determine occupational performance needs and to develop an intervention plan
- Utilizing interpersonal communication skills
- Designing and facilitating therapeutic groups
- Developing individualized teaching and learning processes with clients, family, and significant others
- Coordinating program interventions in collaboration with clients, caregivers, families, and communities grounded in evidence-based practice
- Developing therapeutic programs
- Promoting health and wellness through engagement in meaningful occupations
- Understanding the effects of health, disability, and social conditions on the individual within the context of family and society (ACOTE, 2006).
Participating in continuing education initiatives advances occupational therapy practitioners’ understanding of and capacity to provide interventions that address domestic violence.

Supervision of Other Personnel

When provided as part of an occupational therapy program, the occupational therapist is responsible for all aspects of the service delivery and is accountable for the safety and effectiveness of the service delivery process. The occupational therapy assistant delivers occupational therapy services under the supervision of and in partnership with the occupational therapist (AOTA, 2004). The education and knowledge of occupational therapy practitioners also prepares them for employment in arenas other than those related to traditional delivery of occupational therapy. In these circumstances, the occupational therapy practitioner should determine whether the services they provide are related to the delivery of occupational therapy by referring to their state practice acts, the regulatory agency standards and rules, the domain of occupational therapy practice, and the written or verbal agreement with the agency or payer about the services provided (AOTA, 2004). Occupational therapy practitioners should obtain and use credentials and a job title commensurate with their roles in the specific arena. In such arenas, nonoccupational therapy professionals may provide the supervision of occupational therapy assistants.

The following case studies provide examples of the role of occupational therapy in domestic violence.

Adult Case Study

An occupational therapist working in a shelter for survivors of domestic violence was asked to assess Maria, a 28-year-old woman who has two children.

Assessment

Using the Canadian Occupational Performance Measure, Maria indicates that the following occupational performance areas are the most important to her. She feels competent in her ability to take care of a house, parent her children, and keep them safe. She wants to work with the occupational therapist on finding and maintaining a job, budgeting, and completing her GED. Maria rates her performance as 1—un able to do it, and her satisfaction levels as 1—not satisfied at all, for these performance areas. When budgeting is discussed, Maria states that she had never been responsible for money management. She went straight from her parent’s home into her marriage at the age of 17, and her husband would not allow her to have anything to do with the money. He constantly told her that she was “too stupid” to take care of money. She was not allowed to work outside the home, so she was dependent on her husband for money.

Intervention

The occupational therapist helps Maria to procure and fill out job applications and practice job interviewing skills. After Maria finds a steady job, she and her children move into the shelter’s transitional living program. To stay in this program, Maria needs to put a certain amount of money into a savings account on a monthly basis to secure a home for her and her children. Following her first paycheck, the occupational therapist meets with Maria to project a budget for her expenses and savings. Maria asks the occupational therapist to develop her budget for her because she “isn’t smart enough to do it herself.” She states that math was her worst subject in school. The occupational therapist grades the complexity of the task to enable Maria to develop problem-solving skills and reasoning abilities for budgeting. The occupational therapist then models for Maria how to contact community agencies to obtain information about GED programs. They determine a daily schedule and identify support networks so that Maria can work, complete her studies, and care for her children.

Adult Case Study

An occupational therapist in an outpatient clinic receives a referral to provide occupational therapy services to Mr. Lee, a 72-year-old man with a right distal radius fracture and a boxer’s fracture. Mr. Lee has chronic obstructive pulmonary disease (COPD) and uses a wheelchair for mobility. He has been living with his current partner for the past 10 years. During the evaluation the occupational therapist asks Mr. Lee to explain how the injury occurred. He is vague in his responses and simply states that he became weak and fell out of his wheelchair. Over the next few sessions, while providing interventions to address Mr. Lee’s hand injuries and COPD, the occupational therapist notices additional bruises on his arms and suspects that he is involved in an abusive relationship.

Assessment and Intervention

Because the occupational therapist lives in a state that mandates reporting of abuse in adults, she files a report to the appropriate law enforcement agency. She lets Mr. Lee know that law requires such action. The occupational therapist then initiates conversation about domestic violence. Research (Bacchus, 2003; McCauley, 1998) has shown that victims of domestic violence want their health care provider to ask them about domestic violence, thereby creating a venue for them to open up as they feel able. While continuing to provide interventions related to hand function and energy management, the occupational therapist also reassesses Mr. Lee’s areas of occupation, performance skills, and performance patterns to identify additional home and community supports he may need because of the domestic violence. She provides Mr. Lee with resources on domestic violence and the local crisis number. She includes interventions to focus on building self-esteem and empowerment.

Adolescent Case Study

Heong is a 16-year-old girl in 10th grade. For the past 2 months she has dated a popular young man who is in the 11th grade. Heong initially thought that his frequent phone calls throughout the day were very romantic. He started telling her that he didn’t want her to go out with her friends and got into several fights with Heong’s male classmates. After dating for about 1 month, he began to slap and punch her. The next day he would bring her flowers. Rather than tell anyone, Heong withdrew from her friends and after-school activities; she did not socialize with other boys at school or work.
A representative from the local women’s shelter spoke to Heong’s 10th-grade class about teen dating violence. Realizing that she was a victim of teen dating violence, Heong spoke to her guidance counselor. The counselor referred her to a teen dating violence group run by the school occupational therapist.

**Assessment**

The occupational therapist administers an initial assessment to evaluate Heong’s occupational needs, problems, and concerns. The therapist analyzes Heong’s occupational performance skills, performance patterns, context, and activity demands (AOTA, 2002). After reviewing the results of the initial assessment, the occupational therapist develops collaborative goals with Heong related to her job, leisure activities, and social participation in after-school activities.

**Intervention**

Utilizing a cognitive–behavioral approach, the occupational therapist helps Heong to explore the impact the dating violence had on her work performance, social participation, and her sense of identity. She encourages Heong to identify the importance of leisure occupations in the development of self-esteem, friendships, health, and identity. Together they develop a plan for Heong to participate again in familiar leisure occupations as well as in new ones.

**Infant Case Study**

Jonella brought her 4-month-old daughter, Kia, to an occupational therapist, as part of an early intervention service for infants and toddlers. Jonella tells the occupational therapist that she is concerned about Kia, who sleeps only 30 minutes at a time and consistently wakes up screaming. Jonella explains that she and Kia have just left an abusive relationship and now live with some friends. Since infancy, Kia has been awakened many times because of the shouting and physical violence. In addition, Jonella could not establish a daily nap and sleep routine for Kia because she frequently had to rush Kia out of the house to keep her safe.

**Assessment and Intervention**

The occupational therapist administers the Test of Sensory Functions in Infants and the Transdisciplinary Play Based Assessment to Kia to assess for sensory issues focusing on self-regulation and for potential developmental complications. The occupational therapist and Jonella collaborate to identify strategies for establishing a consistent nap and sleep routine for Kia. The occupational therapist models strategies that Jonella can use to help calm Kia and modulate the amount of sensory input she receives. They also identify strategies for modifying the environment in the room where Kia sleeps and for helping Jonella relax with Kia before putting her to bed.

**Toddler Case Study**

A school system occupational therapist is asked to assess Daniel, a 5-year-old boy. His teacher states that Daniel is having extreme problems with manipulating crayons and performing gross motor activities. The teacher informs the therapist that the mother has just gotten out of a very abusive situation. The mother stated that Daniel’s father would not let her place Daniel in a preschool or a Mother’s Morning Out program. She was not allowed to take Daniel outside to play. In addition, when the father was home, Daniel was expected to sit quietly and was not allowed to play with toys. In spite of these restrictions, Daniel’s mother did her best to expose her son to books and songs and teach him ways to play with household materials.

**Assessment**

The occupational therapist performs the Quick Neurological Screening Test II (QNST II) and sends the Sensory Profile home with Daniel for his mother to complete. Daniel scores within the “Definite Difference” range on the following factors on the Sensory Profile: Emotionally Reactive, Oral Sensory Sensitivity, Inattention/ Distractibility, Auditory Processing, Vestibular Processing, and Multisensory Processing. As measured by the QNST II, Daniel also has difficulty with gross motor skills, balance, tactile processing, visual tracking, motor planning, impulsivity, and anxiety.

**Intervention**

The occupational therapist observes Daniel in the classroom and makes recommendations for strategies that the teacher can use to decrease Daniel’s distractibility and to increase his attention and participation at school. The occupational therapy assistant works with Daniel for 45 minutes twice a week with time divided between intervention in the classroom to address cutting and drawing activities and outside the classroom to increase his motor control, sensory awareness, and problem-solving skills.

**Teen Case Study**

An occupational therapist is part of a diabetic program treatment team. The physician wants the therapist to assess and provide services to Herminie, a 34-year-old woman who is not routinely checking her glucose levels or taking her insulin. Because Herminie speaks limited English, her sister accompanies her to the session and translates for her.

**Assessment**

During the interview, Herminie shares that her 13-year-old daughter has taken on the responsibility for prompting Herminie to perform the techniques necessary to keep the diabetes under control. The 13-year-old daughter also takes care of her 7-year-old brother while Herminie works. Herminie left home with her children a year ago because her husband was physically and emotionally abusive to her. According to Herminie’s sister, as a result of witnessing the abuse, the daughter is continually afraid that something is going to happen to her mother and brother. She is afraid to leave the house, except to go to school, and does not socialize with friends.

**Intervention**

With the aid of Herminie’s sister who provides verbal and written translation, the occupational therapist develops a daily check sheet that Herminie can use to prompt herself to independently check her glucose levels and take her insulin. She discusses with Herminie how important it is for her, rather than her daughter, to be responsible for managing her diabetes. The occupational therapist meets with Herminie and her daughter on a weekly basis for several weeks to reinforce and monitor the progress that Herminie is making and to assist the daughter with reducing her anxiety.
With Herminie's and her daughter's permission, the therapist called the daughter's school guidance counselor to discuss the situation and request help with decreasing the daughter's anxiety while facilitating increased socialization. In addition, the occupational therapist recommends that Herminie participate in a domestic violence counseling program.

References


Authors
Heather A. Javaherian, OTD, OTR/L
Robin T. Underwood, MS, OTR/L
Janet V. DeLany, DEd, OTR/L, FAOTA

for
The Commission on Practice
Susanne Smith Roley, MS, OTR/L, FAOTA, Chairperson

Adopted by the Representative Assembly 2006CO446
Copyright © 2007, by the American Occupational Therapy Association.